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POLICY

U.S. Navy Medicine is basically an official Medical Department publication inviting the attention of officers of the Medical Department of the Regular Navy and Naval Reserve to timely up-to-date items of official and professional interest relative to medicine, dentistry and allied sciences. The items used are neither intended to be, nor are they, susceptible to use by any officer as a substitute for any item or article, in its original form. The opinions and conclusions expressed in the articles or items included herein are those of the respective authors and do not necessarily represent the views of the Department of the Navy, the Bureau of Medicine and Surgery or any other governmental department or agency thereof.

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The issuance of this publication approved in accordance with NAVEXOS P-35.

NAVMED P-5088

CONTENTS

Note: As this issue of U.S. NAVY MEDICINE goes to press, the retirement of the 25th Surgeon General of the Navy is anticipated for 31 Jan 1973. In VADM George M. Davis, MC, USN each member of the Navy Medical Dept. found an inspiring leader, a strong supporter and warm friend. Attention is invited to the review of his term in office, pp. 3–13.

Credits: All pictures are Official U.S. Navy Photographs unless otherwise indicated.

The U.S. Naval Academy photo on our front cover by PHCM Ken Bumpus, USN reveals busy midshipmen moving about "The Yard" during a class change at the Academy. The handsome new Math and Science building is seen in the background. Attention is invited to the article on "Bancroft Medical" which begins on page 20.

The photo on page 2 was taken when VADM George M. Davis, MC, USN, as Surgeon General, visited Naval Hospital Port Hueneme, Calif. Accompanying Admiral Davis were (from left to right): CDR Alice M. Hines, NC, USN; LCDR J.R. Erie, MSC, USN; and CAPT Elgin C. Cowart, Jr., MC, USN, CO, Naval Hospital Port Hueneme.

The continued support of Ms. S.B. Hannan, BUMED Code 2133, and the Illustration and Exhibits and Photography Divisions of the Medical Graphic Arts Dept., Naval Medical Training Institute, NNMC, Bethesda, Md., is gratefully acknowledged.

from the Chief

Two emotions which seemingly conflict are frustration and satisfaction. Since I shall retire on 1 February 1973 I find that I share both of these emotions. My frustration comes from the awareness that in the past four years I have not accomplished as many of those things that I had hoped would enhance the attractiveness of a career in Navy medicine. Yet, most of those that are not implemented as yet have been identified and action has been promised. Hopefully, the near future will bring them to pass.

My satisfaction comes from the knowledge that throughout my term a great Navy medical team has worked quietly and efficiently giving quality care to our eligible patients. Civil servants, officers and enlisted, men and women dedicated and responsive to the Navy's mission, all of you have supported me tremendously. Much remains to be done but a Navy medical system is evolving which promises to serve as a prototype for efficient and satisfying medical care throughout the nation. As we see more and more third party and federal processes moving into the management of health care delivery, a career in the military health system will become more and more attractive.

My advice to you is, "Don't sell yourselves short! Your capacity for professional greatness is there; don't underestimate it!"

My valedictory is, "I am honored and pleased to have been a member of your great team!"

Godspeed and thanks to you all!

G. M. Davis

G. M. DAVIS
Vice Admiral
Medical Corps, USN

PICTORIAL REVIEW of the Surgeon General's Office (1969-1973)

VADM George M. Davis, MC, USN

For the first and only time during his term as Surgeon General, U.S. NAVY MEDICINE has overrode instructions from VADM DAVIS to print only those photos which relate directly to important developments for Navy medicine. We hope to be forgiven for stretching that interpretation just a little, since it is the general consensus that each Chief of the Bureau of Medicine and Surgery embodies the direction and thrust of military medical progress during his era. Whatever the difficulties and circumstances that confront him during his term in office, each Surgeon General brings to that office the leadership and vision with which he is imbued. To separate the man himself from the office which he holds, and further refines, would be to reduce history to a list of dates and places without cogent connection. It is the man whom we respect and admire, and if we have been privileged to receive his immediate counsel and guidance, it is the man whom we shall long remember. Events are somehow recalled in the shadow of the men who shape them.

From a peak in the medical support provided to the Vietnam combat zone, there followed a gradual decline in medical requirements over the past four years with a return of hospital ships REPOSE and SANCTUARY, and phasing out of land-based naval medical facilities such as the NSA hospital at Danang. With the winding down of immediate medical responsibilities, organized emphasis was placed on providing advisory, training and educational assistance for our medical counterparts in the RVN Forces.

Greater attention was accordingly focused on the delivery of medical health care services within the Navy as a whole. No time was lost in the redistribution of resources and revision of obsolete methods. An unprecedented medical construction boom began and continues to evolve. A remarkable concept of Naval Regional Medical Centers (NRMCs) was conceived, formulated, approved and implemented, wherein all local medical facilities within a given geographic area were consolidated into a single command (NRMC) with direct access and reporting to the Surgeon General.

Substantial application of computer technology to the delivery of health care services began in earnest. Central outpatient telephone appointment systems, central dictation and transcription concepts, The Problem Oriented Medical Information System (PROMIS), computer-based laboratory information and EKG systems, automated testing and screening devices and other related systems are rapidly becoming a reality in increasing numbers of medical facilities. A concerted effort to improve our clinical efficiency led to expanded resources through provision for secretarial assistants to physicians, the utilization of MSC personnel to relieve the chiefs of clinical services of

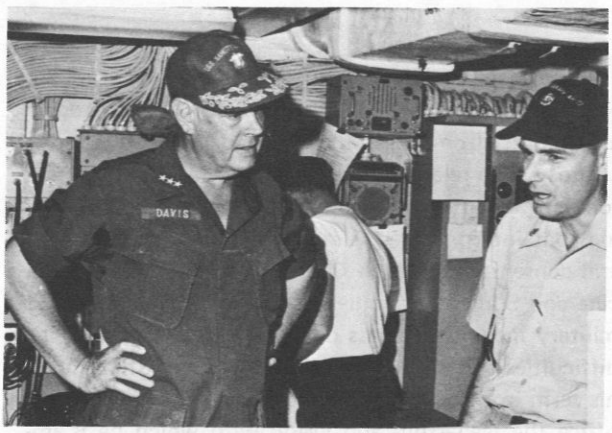
administrative burdens, and improved physical spaces that permit an orderly flow of patients. Increased use of paramedical specialists will follow as the training programs now in progress begin to deliver. Dental programs for plaque control and four-handed dentistry have flourished.

In anticipation of the close of the draft and reliance on all-volunteer Forces, new Navy professional training, education and scholarship programs were highlighted and implemented. Family practice residency training programs now offer interested medical officers an assured career in the Navy's health care system as "primary" physicians. Navy-sponsored scholarships at approved medical, osteopathic and dental schools are attracting highly qualified applicants both from civilian and military communities.

Training and education programs for physician assistants, nurse practitioners and clinical specialists, and university-accredited courses of study for hospital corpsmen, such as in X-ray or laboratory techniques, have been established.

"Project Streamline" initiated new procedural concepts that ultimately came to fruition on 1 Oct 1970

Visiting U.S. Naval Riverine Patrol Force. (Courtesy of CAPT Waring Burke, MC, USN.)



Visiting USS Sanctuary

when the Office of Naval Disability Evaluation (ONDE), under SECNAV, became functional. BUMED provided the impetus necessary to create a Central Physical Evaluation Board, with a fully coordinated and positively directive counseling system for assisting our disabled members of the naval service.

Reorganization of the Bureau to enhance administrative responsiveness to field requirements produced some important functional changes. A vital Fleet and Marine Corps Medical Support Division was established and has already proved its effectiveness in coordinating medical requirements with ship planning and building specifications, for example. A complex, combining elements of Headquarters Operations was placed directly under the Deputy Surgeon General.

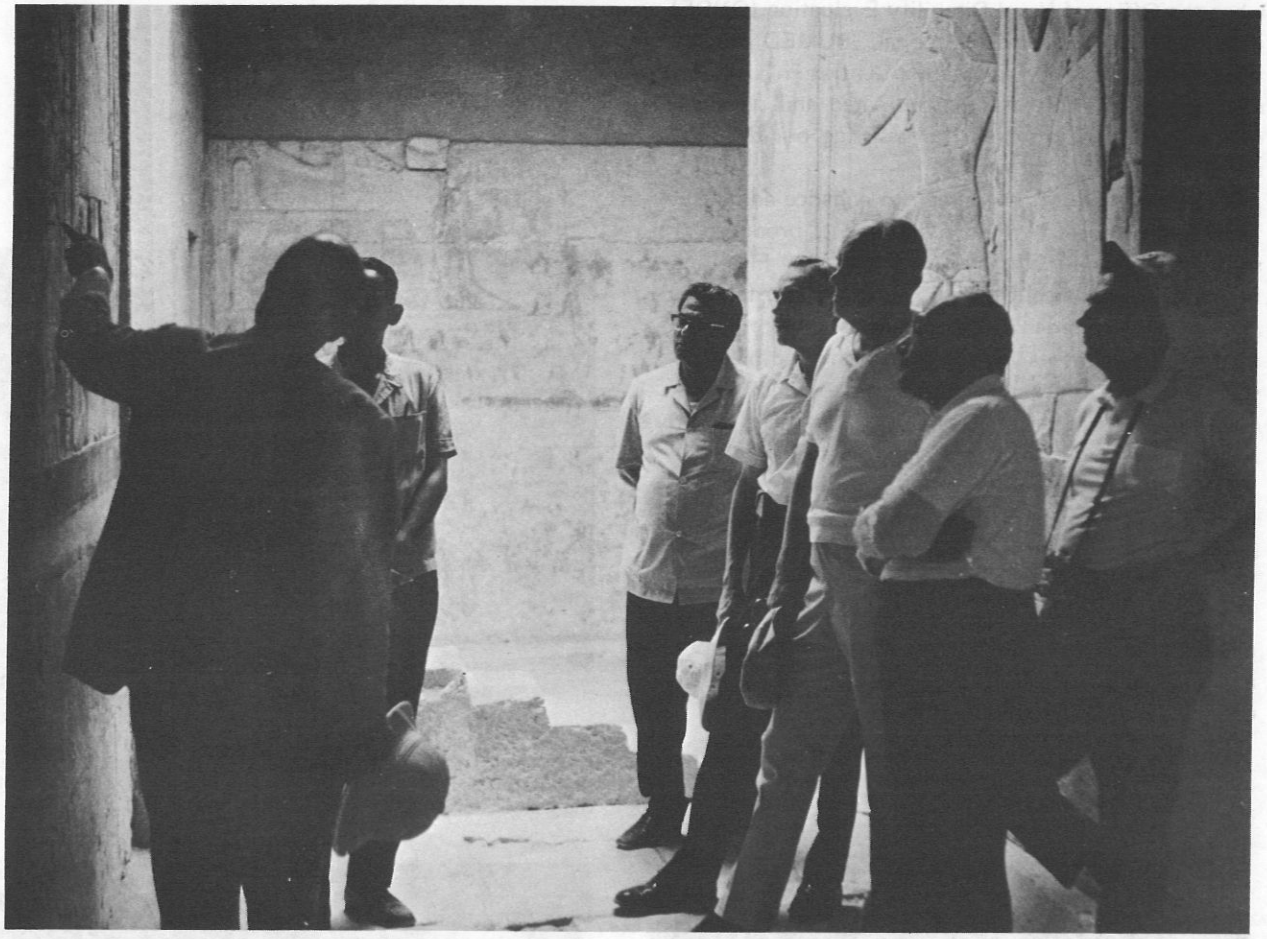
Improved communication and coordination resulted from the establishment of annual meetings for select groups, such as the Specialty Advisory Committees (SAC).

The official publication of the Navy Medical Department was completely revised to provide Navy-oriented and original content, more in line with the highly esteemed *Naval Medical Bulletin* of old.

Cutting the 99th Medical Corps birthday cake on 3 Mar 1970, during the first official celebration of the founding of the Medical Corps on 3 Mar 1871.

Receiving the gavel gift upon concluding term of office as the 1970 President of The Association of Military Surgeons of the U.S.

Welcoming former Secretary of the Navy, John Chafee to the Surgeon General's Conference held in May 1970 at NNMC.



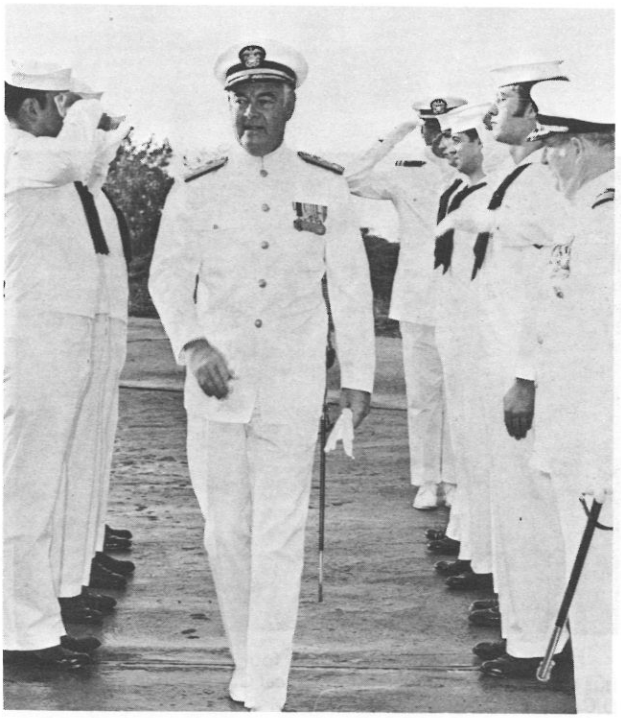
A bit of culture at the tomb of Nefer, during visit to Cairo and NAMRU-3 in 1970. (Photo by courtesy of LCDR James D. Gillentine, MSC, USN.)

Visiting the USS Holland (AS 32)

A Clinical Investigation Program (CIP) was launched and now provides essential resources for research-investigational patient-oriented programs. The program gives every promise of enhancing our training efforts and the quality of medical and dental care.

A trend in flag officer selection was evident during the past few years. Younger eligible physicians are achieving flag rank. The Director of the Nursing Division, BUMED, became the Navy's very first lady admiral. And a "clinical admiral" has been selected.

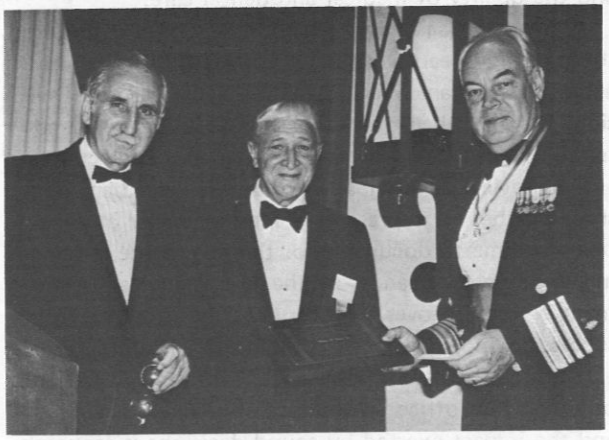
This review is not just a tribute to one man, nor should it be. It represents a modest effort at this point in time to document for the record the developing trends and advances of the Navy Medical Department which, for over a century, has been guided by a succession of distinguished physicians. The unique talents and particular interests that each Surgeon General brings to that office profoundly influence our course, and the impact exerted by sound decisions is far-reaching. As a courageous and prudent leader, a dynamic innovator, a very able and forthright administrator and a highly respected physician, history will accord to Admiral Davis a superlative position among eminent predecessors.



Commissioning ceremony for the newly designated hospital command at Roosevelt Roads in Jan 1971.

Host of the Sixth Conference of the Surgeons General of the Navies of the Americas.

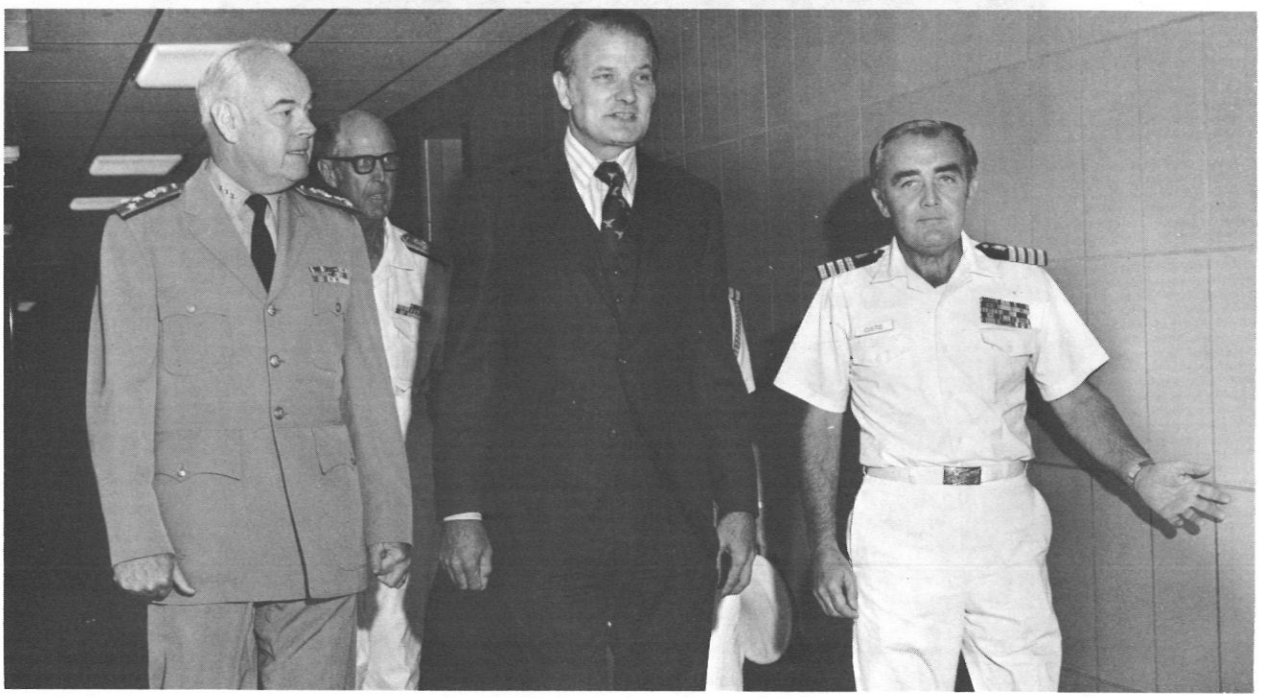
Cutting the birthday cake with four Surgeons General emeritus at the 100th Anniversary Medical Corps Ball in Washington, D.C. in 1971.



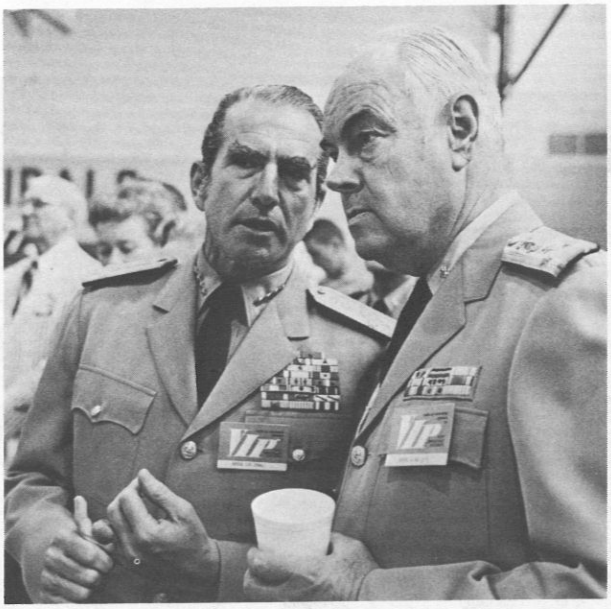
Elected Honorary Fellow of the International College of Dentists in 1971.

Honored by the U.S. Marine Corps and served as reviewing official at the Marine Barracks on 20 Aug 1971 in Washington, D.C.

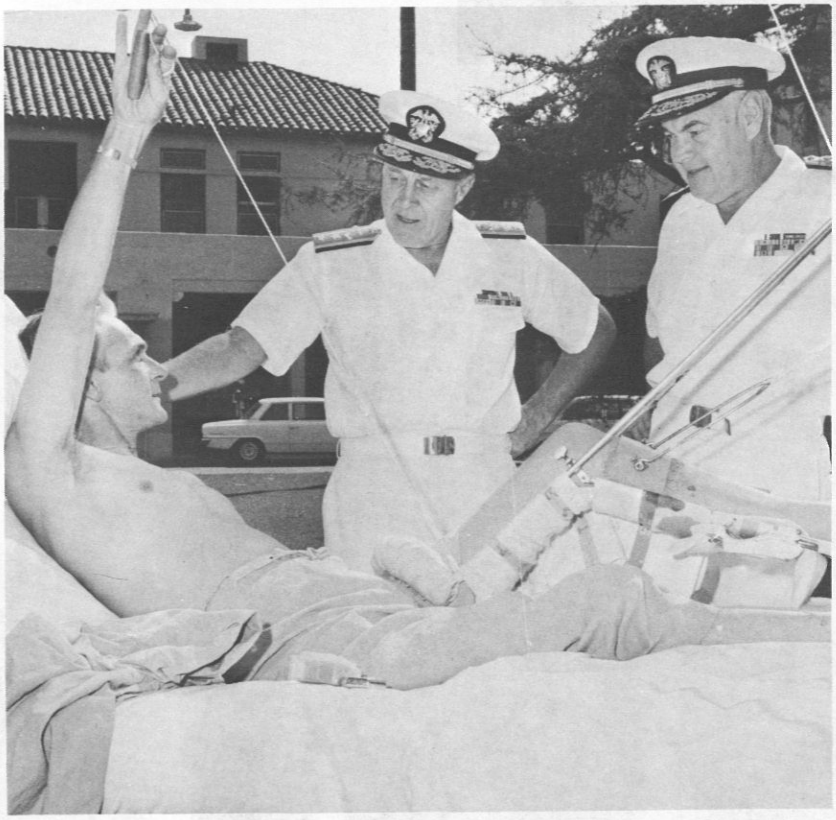
Arriving in fall of 1971, to visit the Naval Hospital Long Beach.



At a briefing on the National Naval Medical Center in Oct 1971.

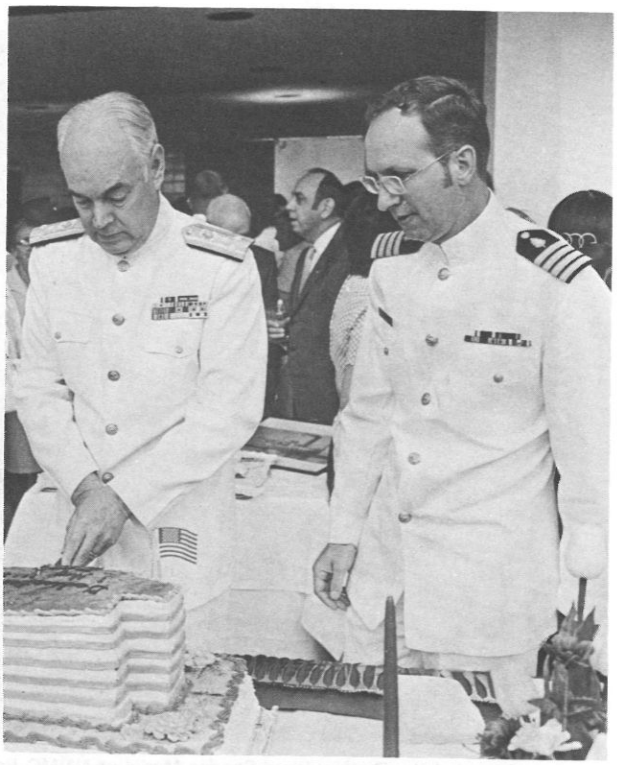


Social Hour at the third Indoctrination and Management Seminar held annually for newly selected captains in the Medical and Dental Corps.

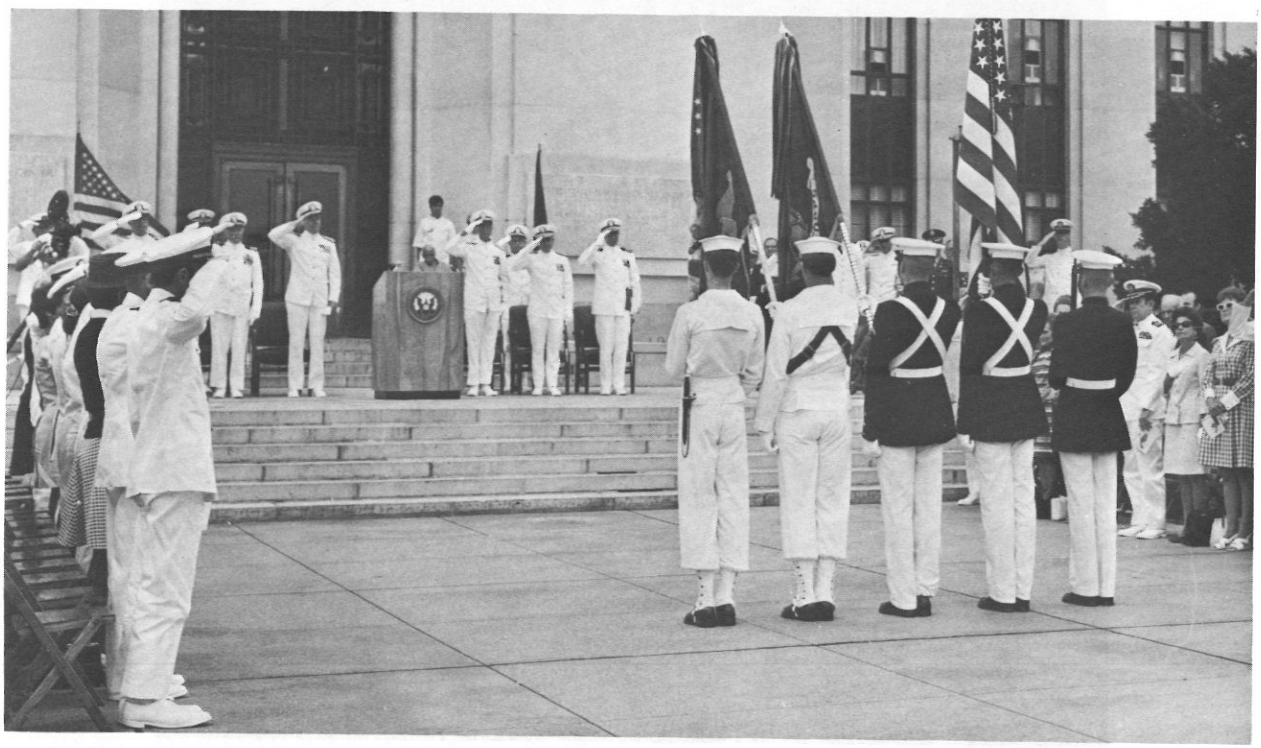


Visiting Naval Hospital San Diego, Calif.

Attending change of command ceremony on 31 Mar 1972 at Naval Regional Medical Center and Naval Hospital Portsmouth, Va. RADM Yon, the first Naval Regional Medical Center Director retired and was succeeded by RADM Arentzen.

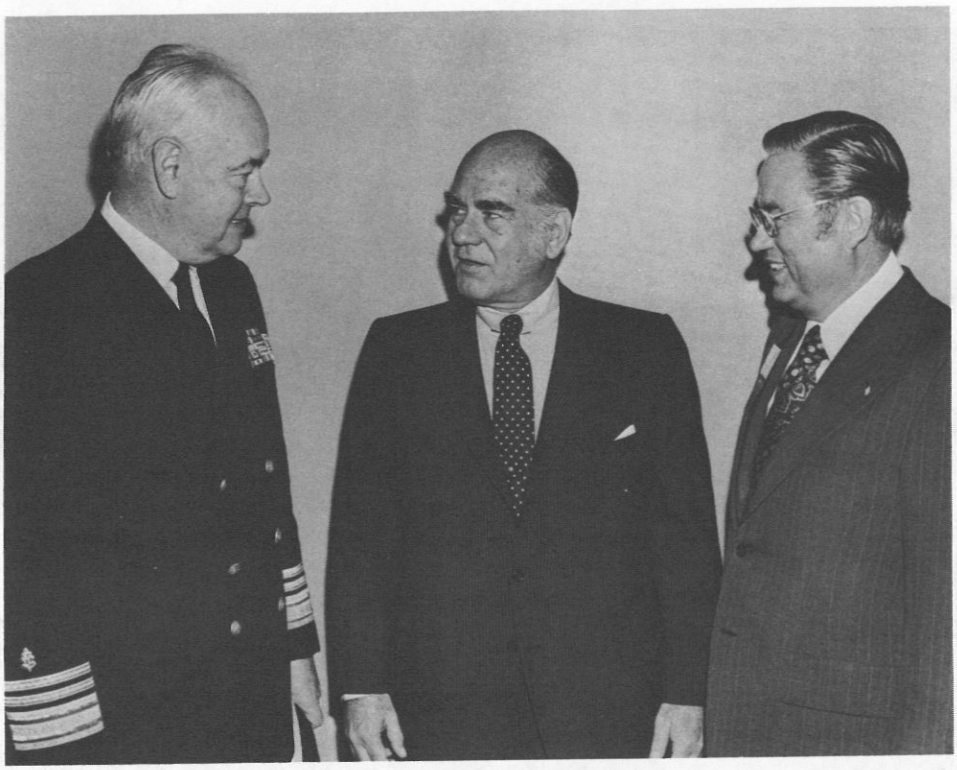


Dedication ceremonies for the new Naval Hospital Memphis, Tenn., on 1 May 1972.



At change-of-command ceremony in Aug 1972 when the Naval Graduate Dental School acquired an officer of flag rank as CO for the first time in its 50-year history.

Awarded the Distinguished Service Medal at NNMC Bethesda — the Nation's third highest award — by SECNAV.

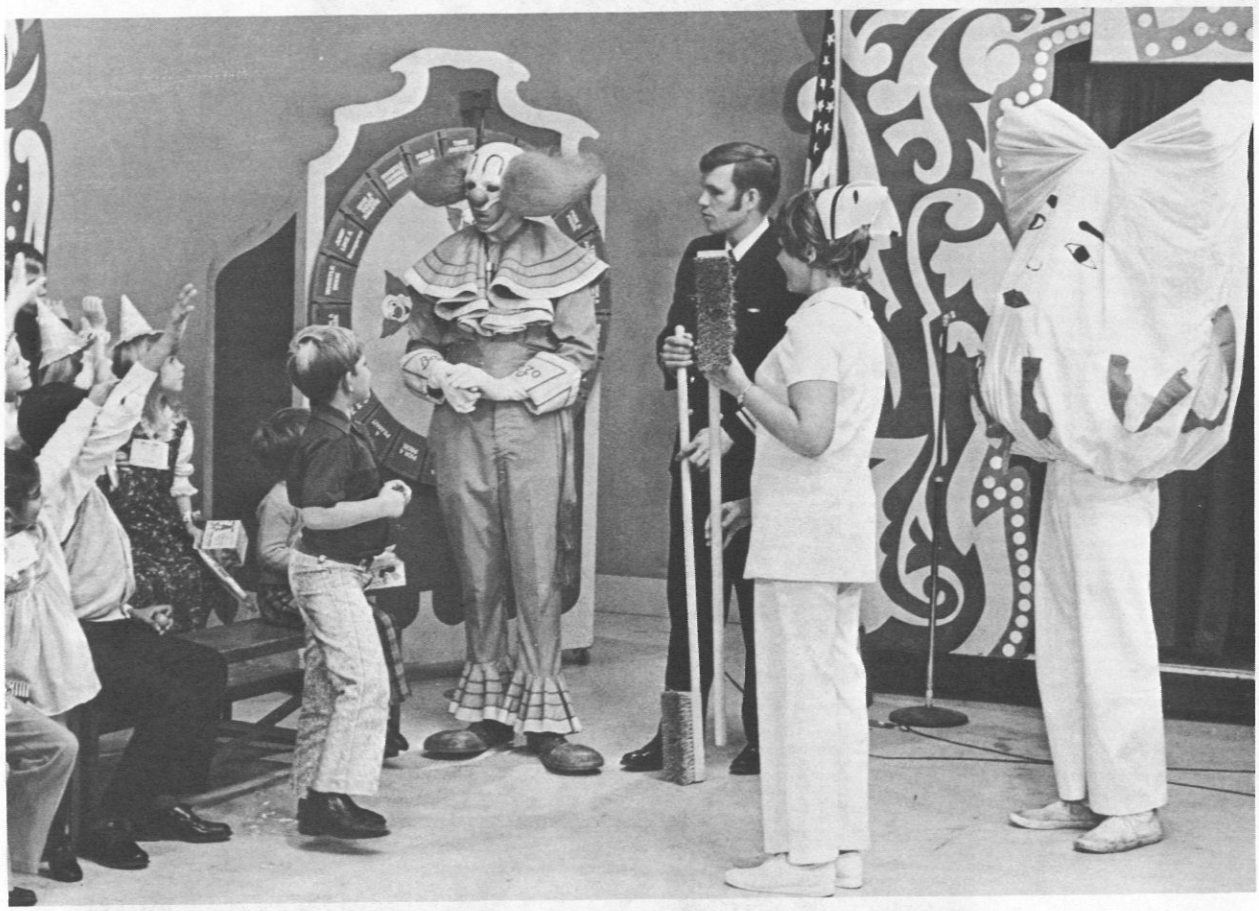


The first military physician elected to honorary membership in the American Dental Association, on 29 Oct 1972.

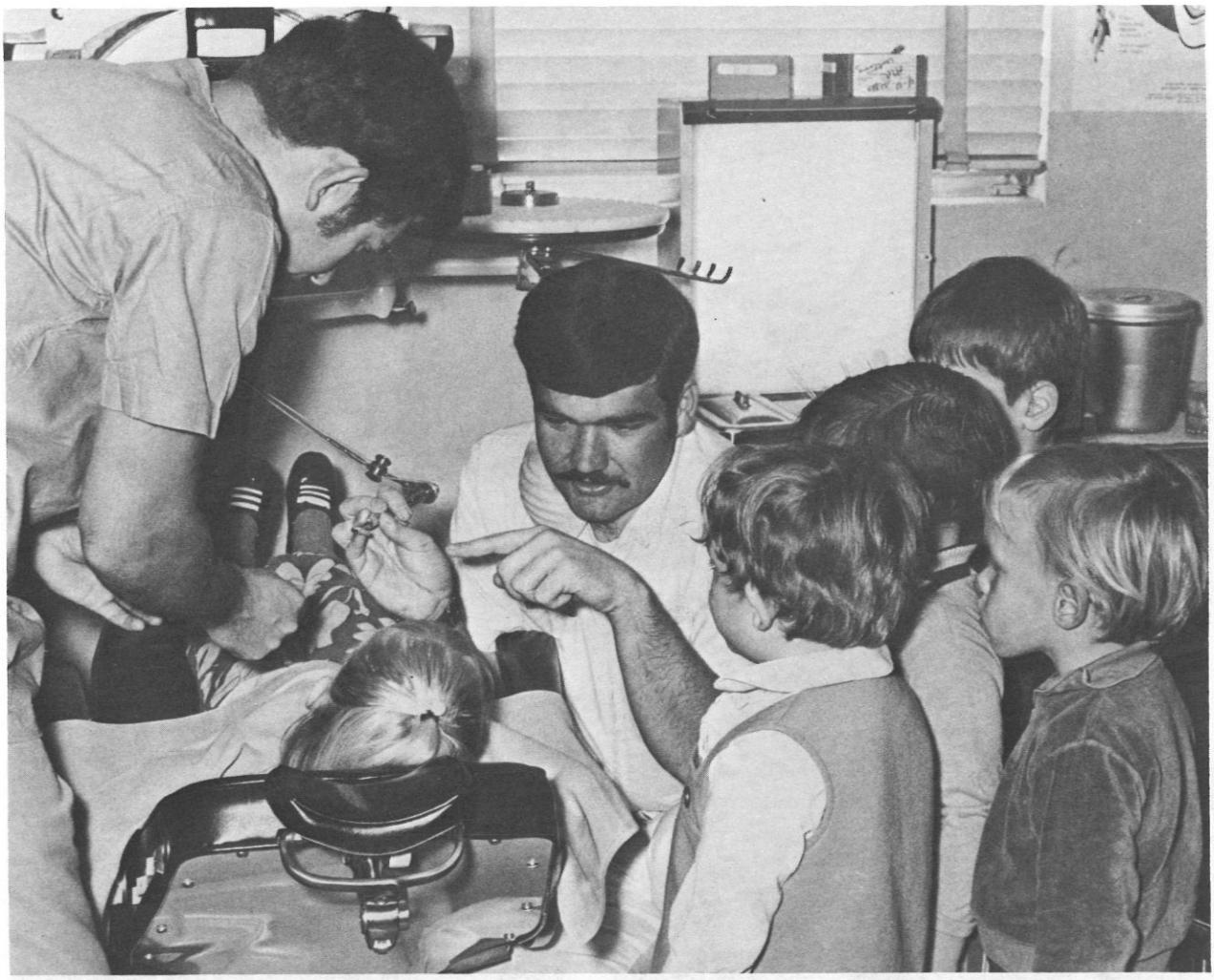
Children's Dental Health Week

During the week of 4-10 Feb 1973, the 25th Annual National Children's Dental Health Week will be observed at Navy dental facilities throughout the world. The theme this year is "Plaque Free in 73." These programs have three common objectives: (1) dental health education and orientation for the child, (2) dental health education and orientation for the parent, and (3) a dental examination and stannous fluoride treatment for the child.

The attitudes and behavior of many people regarding dentistry and dental health can be traced to experiences and information acquired during childhood. A primary purpose of the program is to educate the children regarding dental health and to make their early dental



TV SKIT — DN Janet Vermilya (right) plays the role of a tooth which Mrs. Suzanne Guthrie, RDN and LT Raymond Yukna, DC, USN propose to brush. The skit was a big hit on the Bozo Show, featured on local television.



KINDERGARTEN VISITS DENTAL CLINIC — LT L.A. Scharin, DC, USN (left) and DT2 G.H. Book (right) capture the children's interest and attention.

experiences pleasant. This can be accomplished in classroom discussions, television programs, movies, posters, and most important, by talking to the child individually.

Much of a child's knowledge and most of his attitudes about dentistry are gained from his parents. A child's state of dental health is also determined, primarily, by the parents. It is imperative that proper dental health education and orientation of parents be an integral part of any children's program. It may take the form of presentations to PTA groups, articles in the newspaper, and pamphlets. Parents should be advised of the results of the child's dental examination, and if possible, one parent should be present to have the findings pointed out by the dentist. The parent should also witness and understand any instructions given to the child during the course of the stannous fluoride treatment. As indicated by the theme of this year's program, special emphasis in effective plaque control measures will be given to both the child and parent.

The core of any children's dental health week program is the dental examination and stannous fluoride application. The examination is not a comprehensive one, and merely serves to determine the presence or absence of dental diseases or abnormalities which can be readily detected by a dentist. The stannous fluoride treatment consists of a prophylaxis with a prophylaxis paste containing stannous fluoride, followed by topical application of aqueous stannous fluoride. A stannous fluoride dentifrice, accepted by the American Dental Association is either provided, or its daily use prescribed. Depending upon the facilities available and the number of patients to be treated, the prophylaxis may be administered in groups with the children employing

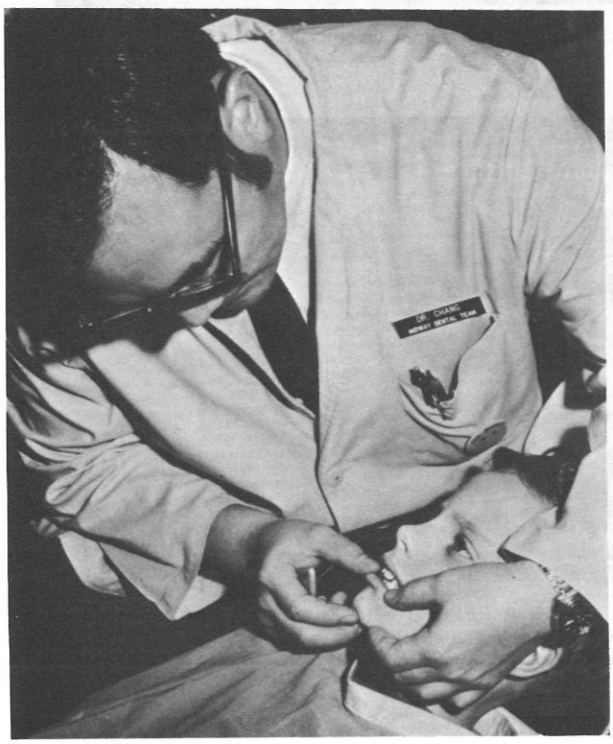
PROGRAM AT SCHOOL — Mrs. Guthrie (left), Dr. Yavorsky (back to camera), Dr. Gill (right) and Principal Hall (right background) participate in a rap on brushing conducted at Midway School.

a prophylactic paste to brush their teeth under supervision, or the prophylaxis may be administered individually by a dentist or dental auxiliary using a dental hand-piece.

Children's Dental Health Week programs in the past have been very popular with both the children and their parents, as well as the dental personnel involved. The children visit the dentist without apprehension, have a good time, and learn some new things about their teeth in the process. The parents are pleased to have their children receive a valuable health service without cost and they also learn about dental health, how to preserve or restore it. While the program often requires extra time and effort of dental personnel, it is a very rewarding professional experience to work with the children in this manner.

The 1971 program at the Naval Training Center, Orlando, Fla., demonstrated the many facets presented by a children's dental health week program. Orlando's program involved, among other things a television show, visits by dental personnel to schools, and visits by children to the dental clinic.

HERE WE BE — Children of the crew wait in the lobby to participate in the Dental Hygiene Program, USS Midway.



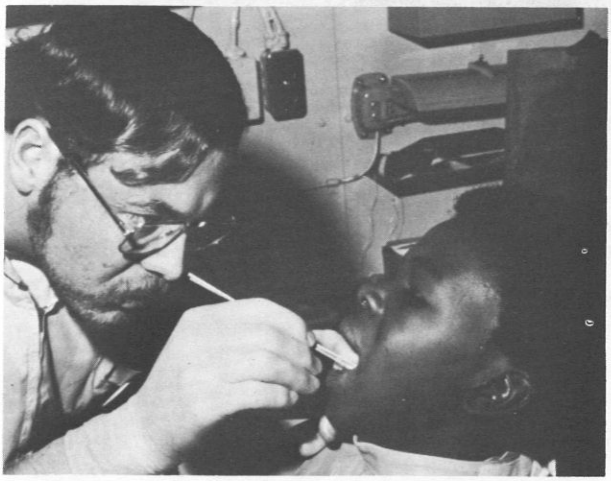
VERY GOOD — Oral examinations were conducted by three dental officers in USS Midway.

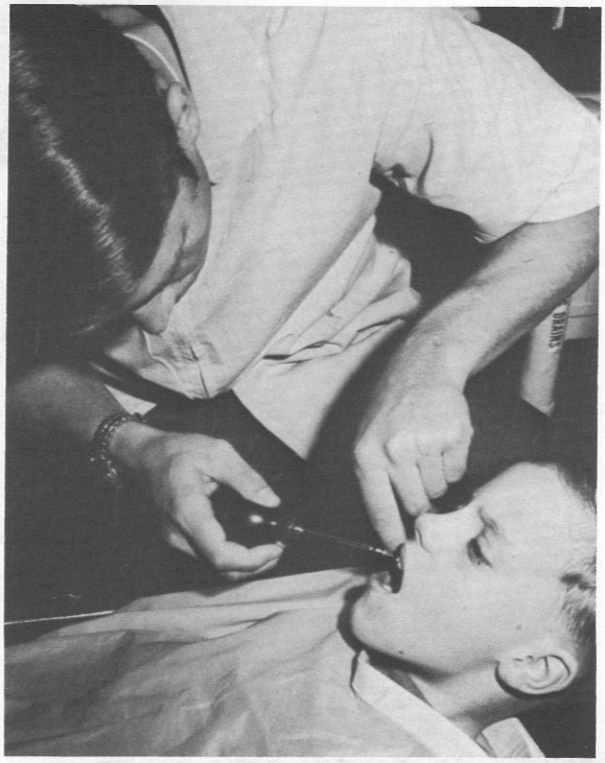
In conjunction with National Children's Dental Health Week in 1972, approximately 200 children of USS *Midway* crewmembers participated in a dental program held in the attack aircraft carrier. CDR Robert E. Cassidy, DC, USN headed the project which served to instill in the children and their parents the importance of oral hygiene.

Each child received an oral examination and an application of stannous fluoride. Parents were then given a written report of their child's dental status, a copy of MIDWAY's preventive dentistry booklet, and the opportunity to discuss with the examining dentist any problems concerning their child's oral health. Following their visit to the MIDWAY Dental Department, two children's movies on oral hygiene were viewed, followed by a question-and-answer period directed by LCDR Whitlock, DC, USN.

The children also received a Dental Care Kit, consisting of an oral hygiene book, toothpaste and brush, and several disclosing tablets. To stress the importance of oral hygiene care, a Certificate of Membership in the MIDWAY Dental Team was presented to each participant. The certificates indicated that, "This membership will be in force for one year or until such time that the member does not actively fight against those desperate outlaws, Terrible Tooth Decay and his sidekick Relentless Plaque, as they ride endlessly through Cavity Canyon."

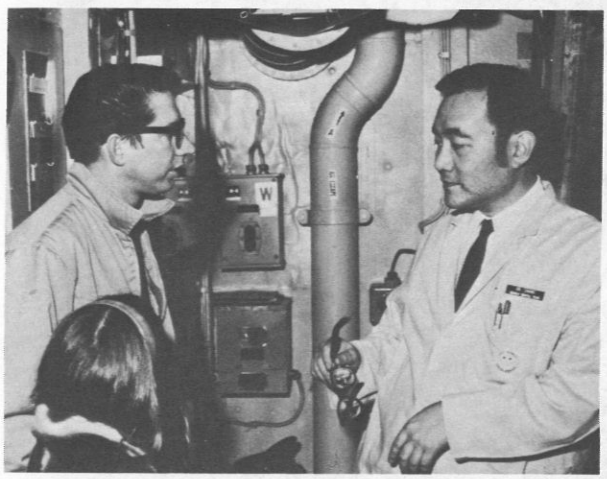
On leaving MIDWAY, each child received a "USS MIDWAY SMILE POWER" button.



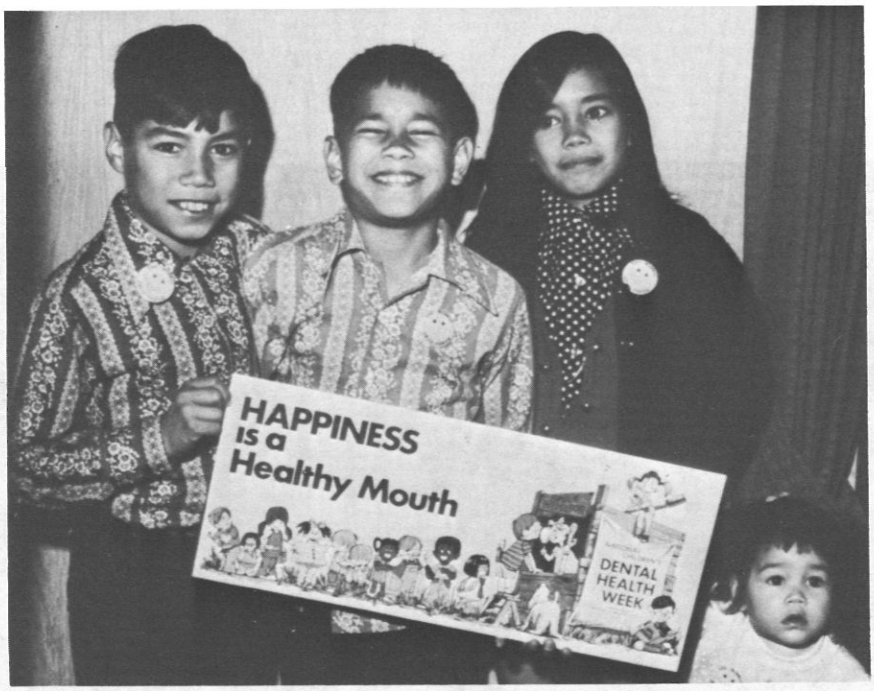


USS MIDWAY (CVA-41) — Fluoride treatments were given by dental technicians.

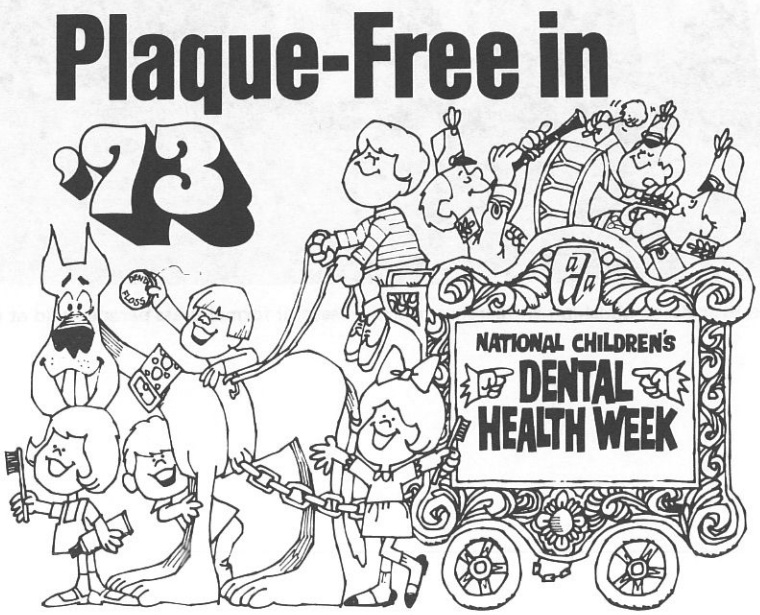
CHILD'S ORAL HEALTH — CDR R.E. Cassidy, DC, USN (right) discusses situation with father of impressionable little patient.

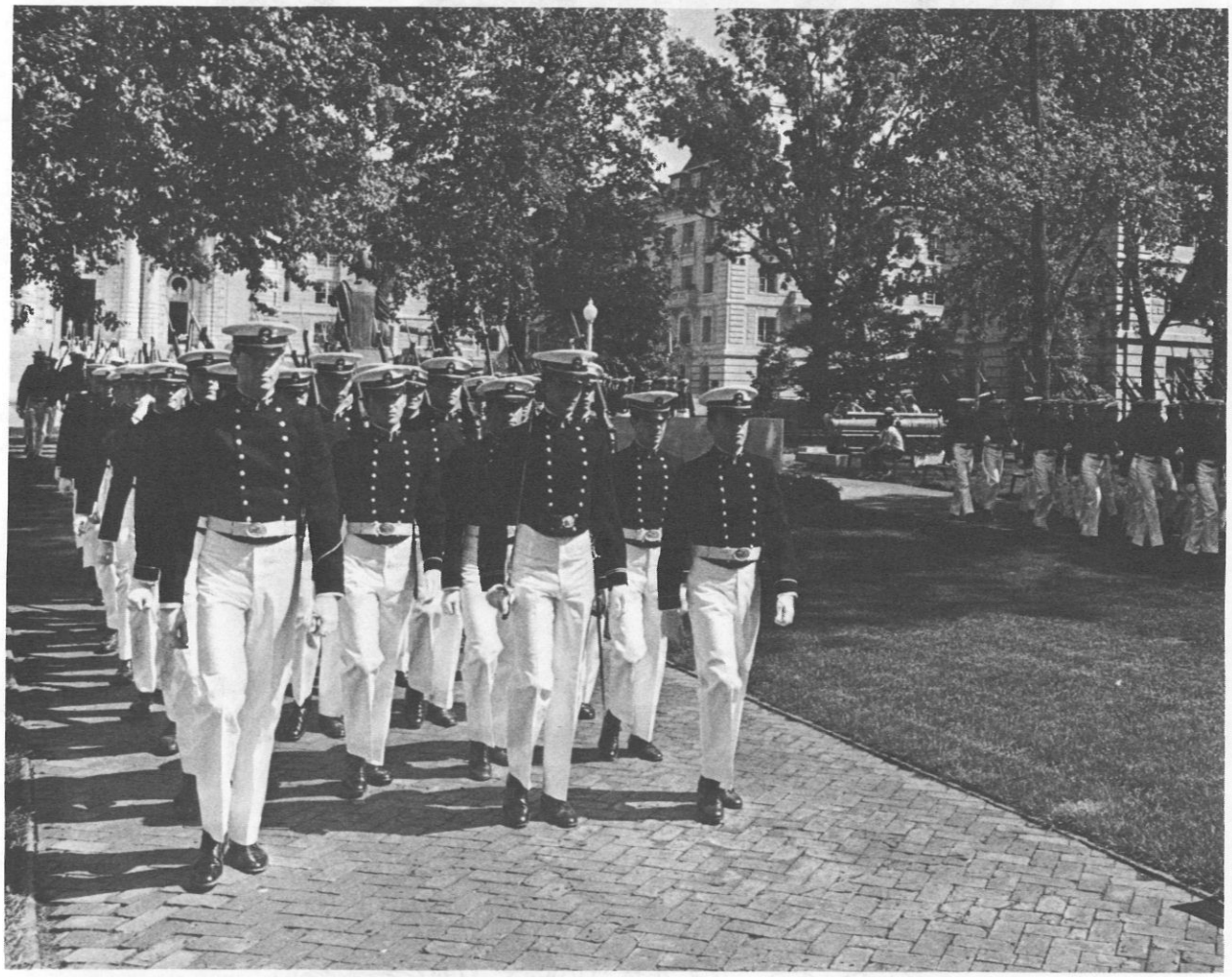


GETTING A REPORT — A MIDWAY crewmember discusses his little girl's dental status with LT Ronald SN Chang, DC, USN (right).



TWO YES, ONE MAYBE — Following oral examination and fluoride treatment, children leave USS Midway flashing spontaneous smiles.





DRESS PARADE.—The Brigade of Midshipmen marches to one of several formal dress parades held at the Academy during the Spring and Fall terms.

USNA BANCROFT MEDICAL

By PHCM Ken Bumpus, USN,
Staff Photojournalist, Public Affairs Office,
U.S. Naval Academy, Annapolis, Md.

In a recent interview, VADM William P. Mack, Superintendent of the U.S. Naval Academy remarked: "We look after our midshipmen here; we look after them very carefully."

Under the leadership of CAPT Roger Stevenson, MC, USN, Senior Medical Officer, the 31 enlisted corpsmen and eight doctors of the Naval Academy Medical Department play a very important role in carrying out this policy by providing health care to more than 4,000 young men of the Brigade.

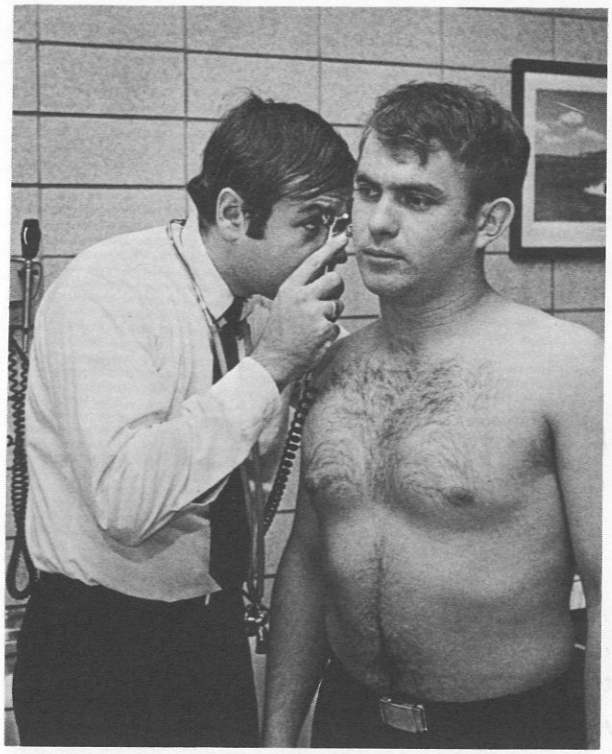
In addition to the day-to-day treatment of aches and pains, the Department conducts physical examinations of Academy candidates, pre-commissioning and officers' annual physicals.

The Medical Department in Bancroft Hall maintains a 15-bed ward but limits confinement to short-stay patients who require only rudimentary care for one or two days, such as postoperative dental patients, or those with minor ailments. For patients who require other hospitalization, surgery or major treatment, Bancroft Medical is backed up by the Naval Hospital, Annapolis.

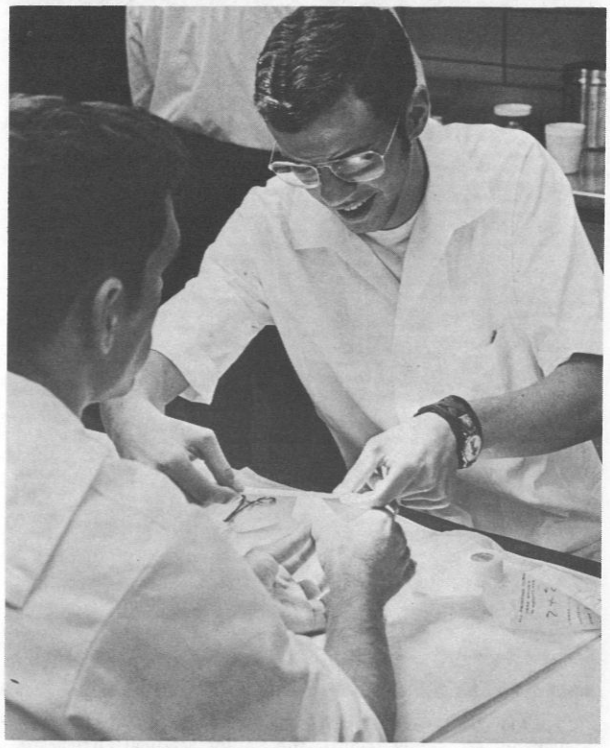
At Sick Call the staff sees a monthly average of 5,600 cases in addition to conducting more than 300 physical examinations per month.

Another functional aspect of the Medical Department, which is unique among Navy Dispensaries, is the

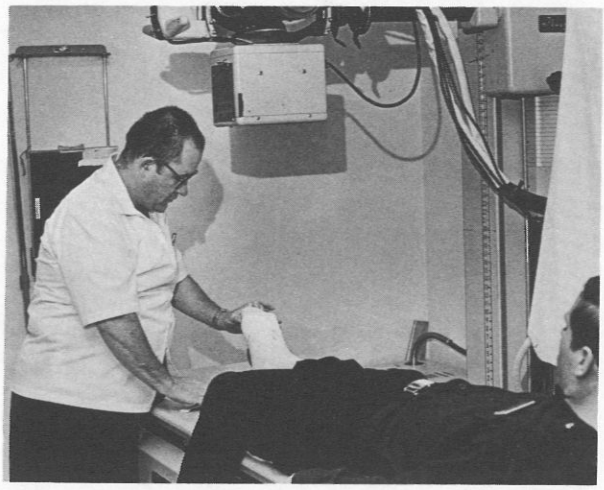
HEAD OF THE MEDICAL DEPARTMENT.—CAPT Roger Stevenson, MC, USN (right), the Senior Medical Officer, is briefed on work in progress by LCDR William H. Benedict, MSC, USN (left), Administrative Officer of the Naval Academy Medical Dept.



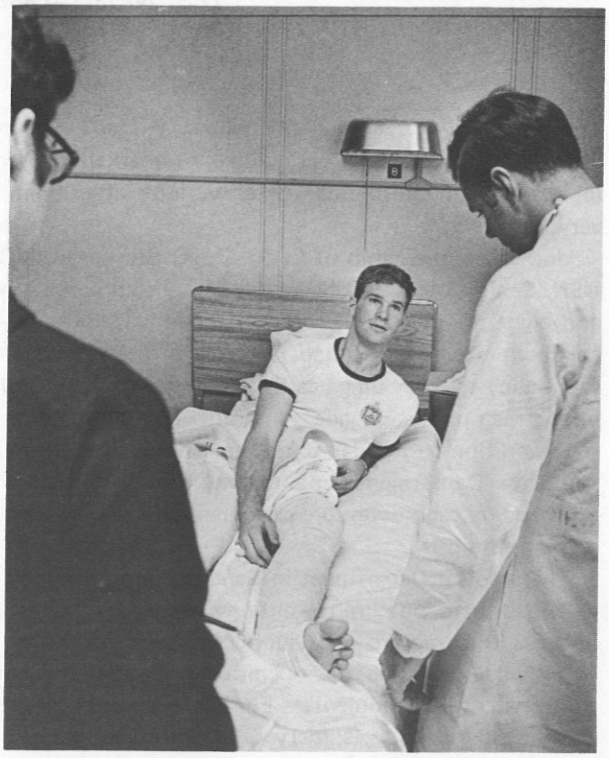
Midshipman First Class James J. Harrison of Middletown, R.I. (right), receives a careful ear examination by LT James S. Murphy, MC, USNR.



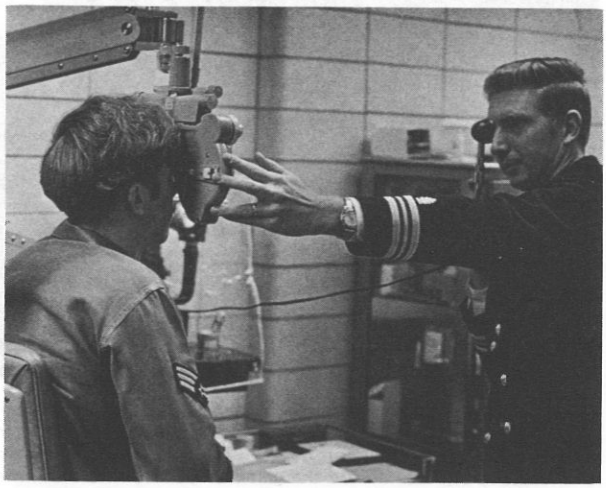
Midshipman Fourth Class Edward A. Harper of Chesapeake City, Md. (left), has his thumb dressed by Hospital Corpsman Third Class G.E. Benya.



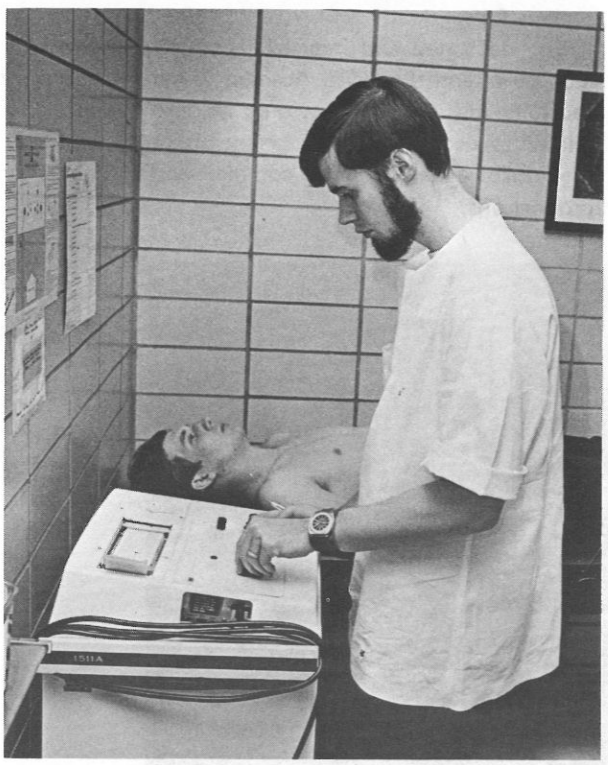
Hospital Corpsman First Class K.C. Poland (left) positions the cast-covered ankle of Midshipman Second Class Mark D. Sullivan of Virginia Beach, Va., who requires an X-ray study of his injury.



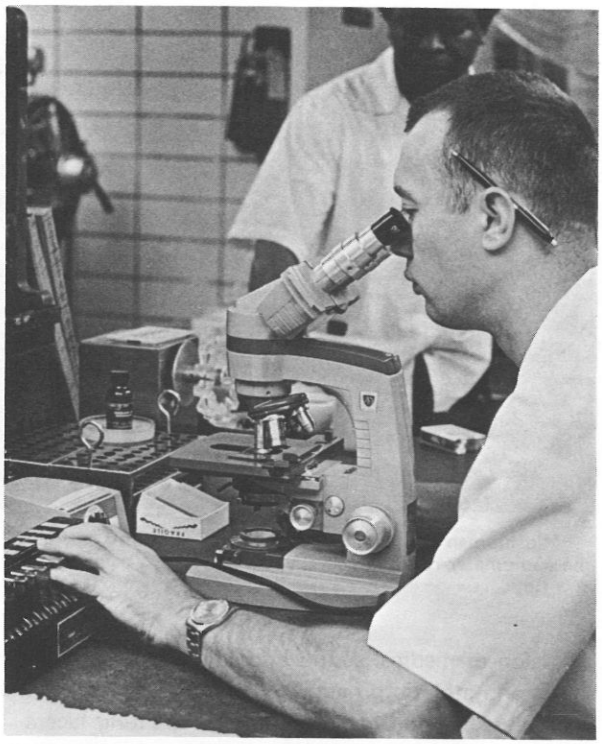
LT William S. Blomquist, MC, USNR (right) and Hospital Corpsman Third Class J.T. Morris make morning "rounds" on patients in the ward. Here Midshipman John W. Berkley (center) of Willingsboro, N.J., discusses his injured leg with them.



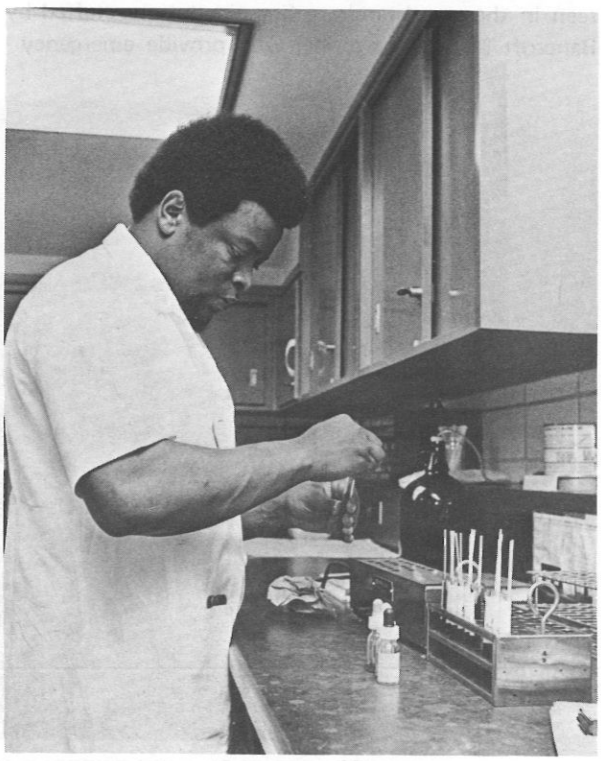
A prospective candidate for the Academy gets an eye checkup performed by LCDR Donald T. Veckarelli, MSC, USN.



Applicants for entrance to the Naval Academy receive a thorough physical evaluation including an electrocardiogram, being obtained here by Hospital Corpsman Third Class R.L. Strudell.

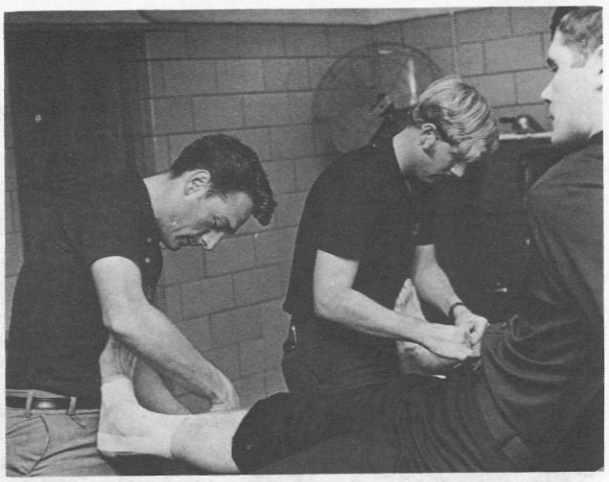


Hospital Corpsman First Class G.O. Hayberger of Gettysburg, Pa., performs a blood count.



Hospitalman A. Livingston of New Iberia, La., processes blood samples taken from Academy candidates.

Midshipman candidates undergo hearing acuity testing in the audiometer room which is equipped to test eight persons at a time.

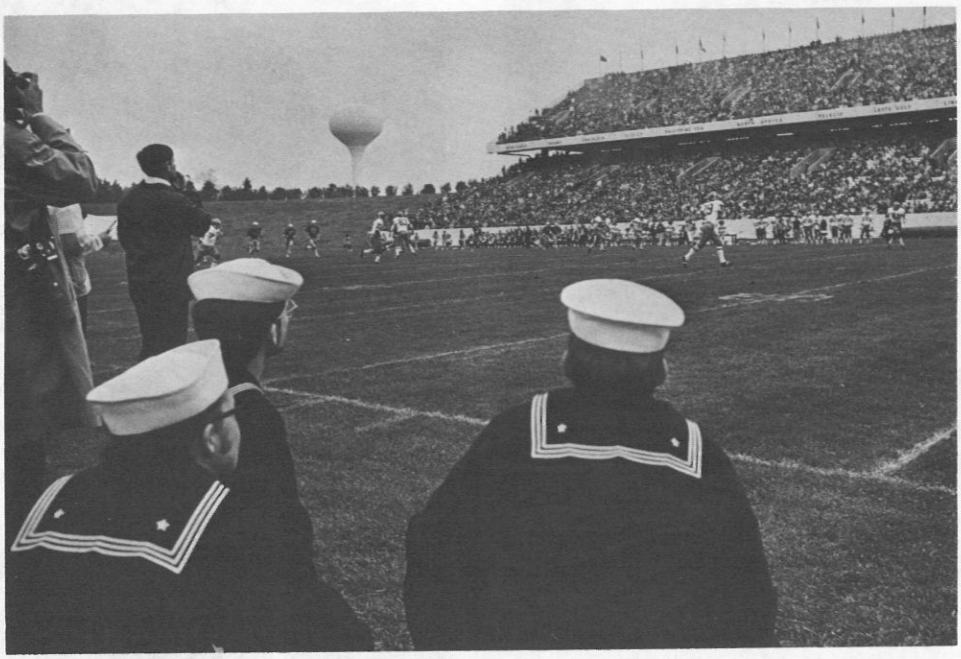


At the Halsey Field House, Hospital Corpsman First Class Ray Chronister (left) of Houston, Tex., and Hospital Corpsman Third Class Dennis Johansen of Askov, Minn., tape the ankles of Academy athletes before the game in an effort to diminish the chances of injuries.

provision of medical support for the Naval Academy's sports and athletic program. Seven corpsmen and one doctor assume the responsibility for treating lacerations, contusions and sprains presented by the Academy's intramural and varsity athletes.

An ambulance with from two to four attendants is present at each of the Academy football games. Unseen in the grandstand are first-aid stations staffed by Bancroft Medical personnel who provide emergency treatment to spectators for everything from overindulgence in hot dogs, to palpitations suffered by overzealous fans.

The dedicated and industrious staff of Bancroft Medical attend the Naval Academy's midshipmen very carefully indeed. By providing medical support to related aspects of Naval Academy life and activities, their involvement assumes complex and challenging proportions.



RAPT ATTENTION WITH TWOFOLD PURPOSE.—A fringe benefit of being attached to the Naval Academy Medical Department is pulling duty at the football games. These three corpsmen, however, must be alert and ready to assist the athletes in the event of any serious injuries.

THE GASTROENTEROLOGISTS' CORNER

Therapeutic Endoscopic Pancreatocholangiogram

By LCDR Otto T. Nebel, MC, USNR*
Naval Hospital San Diego, Calif.

INTRODUCTION

Recent reports indicate that the dream of endoscopic cannulation of the ampulla of Vater has become a reality and that the pancreatocholangiograms obtained by this technique may be useful in the diagnosis of a variety of pancreatic and biliary tract diseases.[1,2,3] The purpose of this paper is to report a case in which the procedure proved therapeutic as well as diagnostic.

Case Report

A 41-year-old male was admitted to the hospital for evaluation of gradually increasing jaundice which began three weeks before admission. He had had multiple admissions in the past for alcoholism, and liver biopsy had revealed evidence of Laennec's cirrhosis six months prior to the current hospitalization. There was no history of pancreatic or biliary disease.

Physical examination revealed a jaundiced male who demonstrated the usual findings of cirrhosis, but who was mentally clear. His admission laboratory data is summarized in Table I. The bilirubin ranged from 25 to 30 mg %, with 15 to 20 mg % direct-reacting bilirubin. The patient remained mentally alert and laboratory tests for prothrombin time, partial thromboplastin time and serum proteins remained within normal limits.

TABLE I.

Admission Laboratory Examinations

Normal: Hemogram
Serum Protein Electrophoresis
Electroencephalogram
Amylase

SGOT/SGPT: 112/64 units (N = <40)

Alkaline Phosphatase: 200 units (N = <45)

Bilirubin/Direct: 28.0/20.4 mg %

Because the cholestatic jaundice occurred in the absence of hemolysis, liver decompensation or renal disease, common duct obstruction was considered a likely possibility. Duodenoscopy revealed no abnormalities and cannulation with pancreatocholangiogram

*Gastroenterology Branch, Medical Service, and the Clinical Investigation Center, Naval Hospital, San Diego, California 92134.

The opinions or assertions contained herein are those of the author and are not to be construed as official or reflecting the views of the Department of the Navy or the naval service at large.

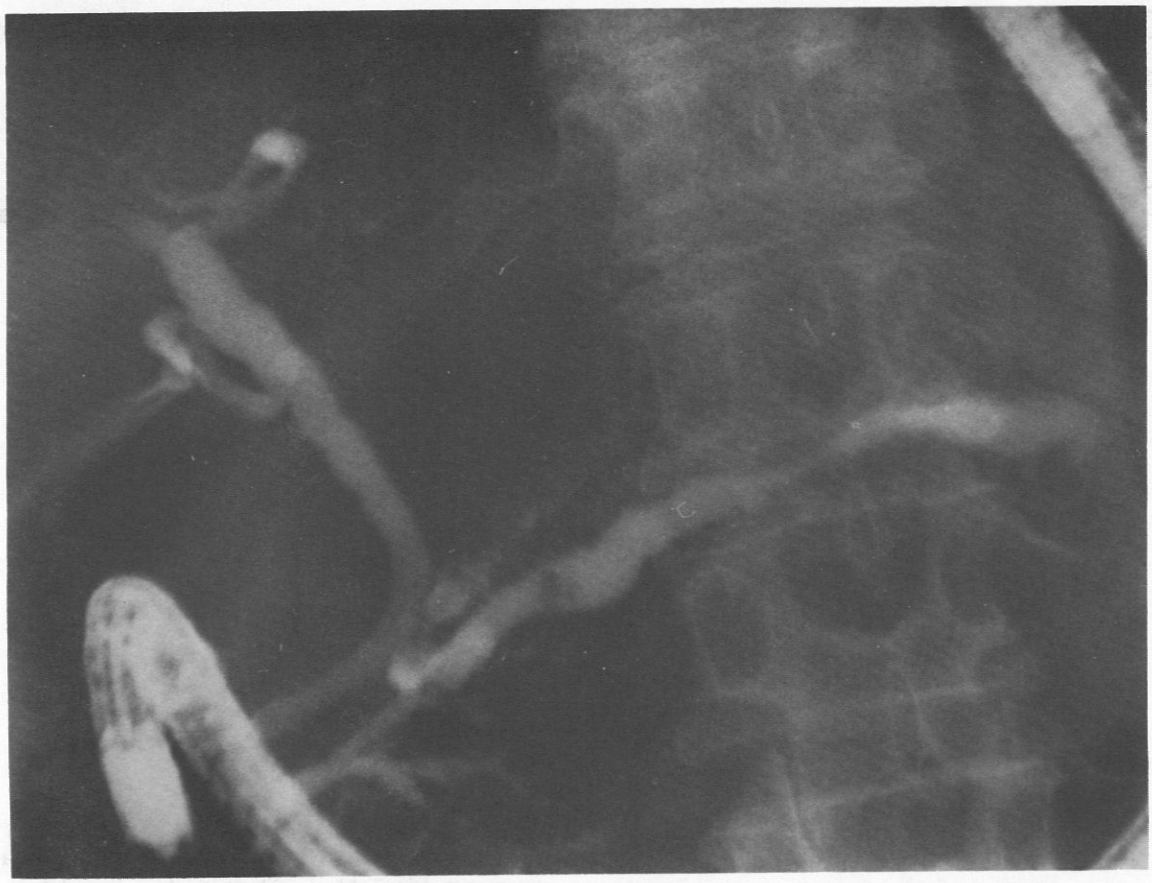


Figure 1.—Pancreatocholangiogram showing marked pancreatic duct deformity with several radiolucencies and a radiolucent stone in the common bile duct.

revealed a dilated, irregular pancreatic duct with multiple radiolucent stones. The common duct was slightly dilated and also contained a stone. (See Figure 1) During this examination adequate radiographs of the gallbladder and intrahepatic ducts were not obtained. Within 24 hours after cannulation, the patient's bilirubin dropped to 12.2 mg %, and then to 10.8 mg % with 8.4 mg % direct-reacting bilirubin. There was no increase in serum amylase and the bilirubin value gradually fell to 3.4 mg %. Because of the possibility of cholelithiasis, a cholecystogram was attempted but the mild hyperbilirubinemia prevented adequate visualization. Duodenoscopy with repeat cholangiogram was therefore performed, revealing a normal gallbladder and biliary tree with continued presence of pancreatic duct stones.

It seems likely that this patient's obstructive jaundice was caused by a pancreatic duct stone that had lodged in the distal common channel and was dislodged during the initial procedure. This explanation is supported by the finding of a normal biliary tract, although the remote possibility of a solitary gallstone that was subsequently passed cannot be entirely ruled out.

DISCUSSION

Recent reports from Japan and from this country indicate that endoscopic pancreatocholangiography may be a valuable addition in the evaluation of pancreatic and biliary disease.[1,2,3] Success in visualizing the desired ductal system has been reported in from 57 to 95% of cases, depending on the ductal system desired, as well as the experience of the endoscopist.

The present case demonstrates one of the problems frequently encountered by clinicians, that is, a patient with known alcoholism and cirrhosis who presents hyperbilirubinemia and a suspicion of common duct obstruction. Because most diagnostic tests of the biliary tract are precluded by the presence of hyperbilirubinemia, the usual procedures commonly employed in the management of these patients are watchful waiting or transhepatic cholangiograms. The patients are frequently poor operative risks, and because trans-

hepaticholangiography is associated with significant morbidity and mortality, the general decision to follow such cases clinically may occasionally delay needed surgery. Retrograde endoscopic pancreatocholangiography is unaffected by the patient's bilirubin level and providing precautions are taken to exclude air bubbles, it is an excellent method for demonstrating the presence of common duct stones.

This case also points up a useful function of endoscopic pancreatography in the evaluation of unsuspected, or poorly documented, pancreatic disease. It is especially helpful in those cases where the secretion test is nondiagnostic or the disease is not manifested by malabsorption or pancreatic calcification.

Pancreatocholangiograms must be carefully evaluated, as the clinical experience with this technique is not extensive and false impressions can easily result. Interpretation is usually satisfactory in instances of cholelithiasis and chronic pancreatitis, but is more difficult when neoplastic disease is suspected.

Our experience with over 50 patients lends further support to reports of the diagnostic usefulness of endoscopic pancreatocholangiography in obstructive jaundice and in a variety of pancreatic and biliary diseases.

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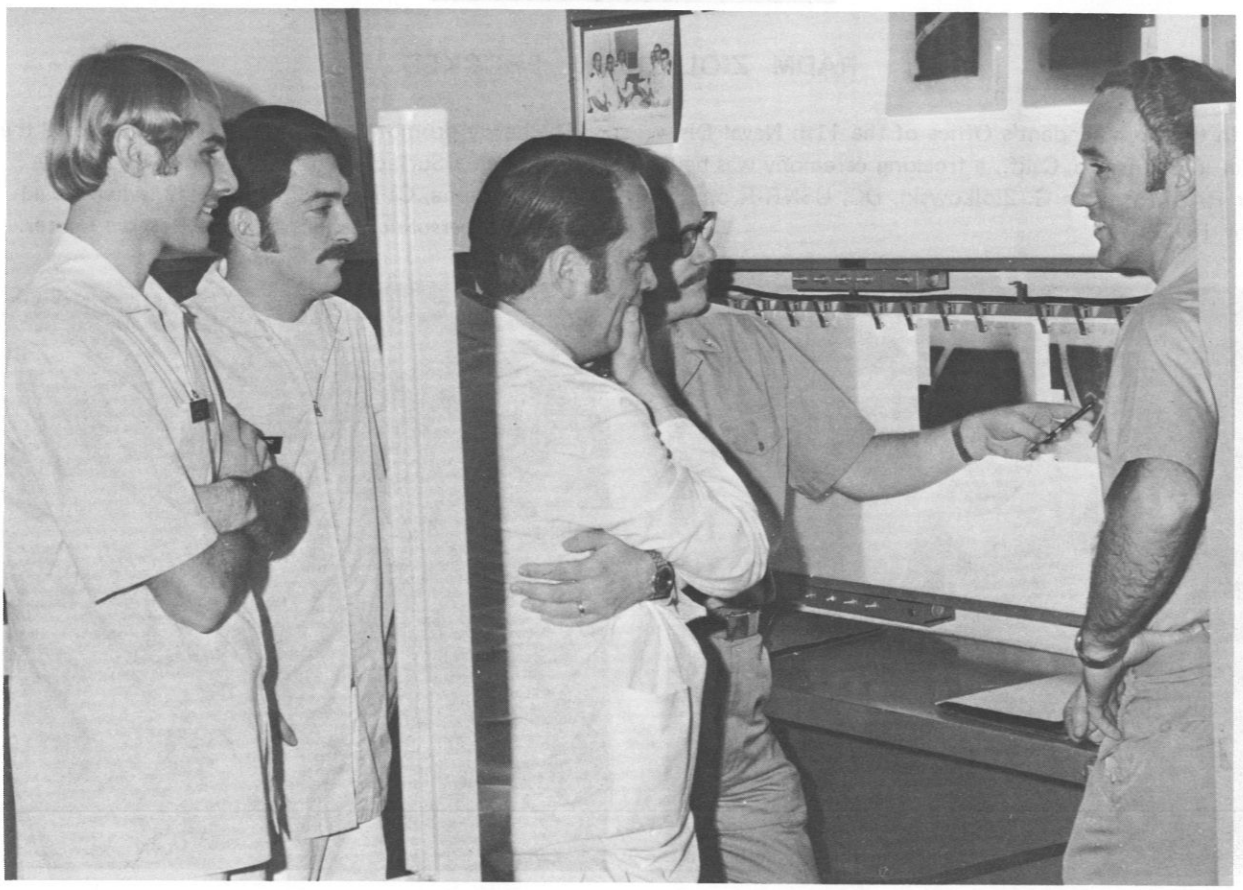
3. Kasugai T, Kuno N, Kizu M, Kobayashi S and Hattori K: Endoscopic pancreatocholangiography. II. The pathological endoscopic pancreatocholangiogram. Gastroenterology 63: 227-234, 1972.

4. Ogoshi K, Niwa M, Hara Y and Nebel O: Endoscopic pancreato-cholangiography in the evaluation of pancreatic and biliary disease. Gastroenterology, to be published, vol 64.



Gastroenterology group at San Diego Naval Hospital includes, from left to right: J. Pfeiffle II, D. Wright, CDR M. Fornes, MC, USN (Head, GI Branch), Drs. O. Nebel and J. Finely.

COMMENT

Gastroenterology — Coast to Coast

The foregoing article from the Gastroenterology Staff at the Naval Hospital San Diego, hopefully represents the first of a series of original manuscripts from this group. It seems appropriate that this paper be included in The Gastroenterologists' Corner which has originated from the Naval Hospital Philadelphia, as a continuous series, for the past three years. Training in the subspecialty of Gastroenterology in the Navy had its origins at Philadelphia Naval Hospital, with the subsequent development of a program at Naval Hospital Bethesda.

The appearance of a manuscript from the San Diego group heralds the beginnings of subspecialty training in Gastroenterology on the West Coast, with the establishment of an approved fellowship in this subspecialty to begin at San Diego in July, 1973. This program represents the combined efforts of CDR Michael F. Fornes and LCDR Otto T. Nebel in establishing training in this field at their hospital. Drs. Fornes and Nebel are graduates of the training programs at Bethesda and Philadelphia, respectively; and one would hope that proliferation in training of this sort is only another manifestation of the growth of excellence in the academic programs presently available in the U.S. Navy.

As the director of the oldest established gastroenterology program in the Navy, it is particularly pleasing to me to see the fruits of our efforts become disseminated across country. Certainly, the establishment of a well structured and academically oriented training program in San Diego by highly competent clinicians, teachers, and clinical investigators is a step in a very positive direction.

It gives me particular pleasure to select Dr. Nebel's paper, "Therapeutic Endoscopic Pancreatocholangiogram," for publication this month in U.S. NAVY MEDICINE.

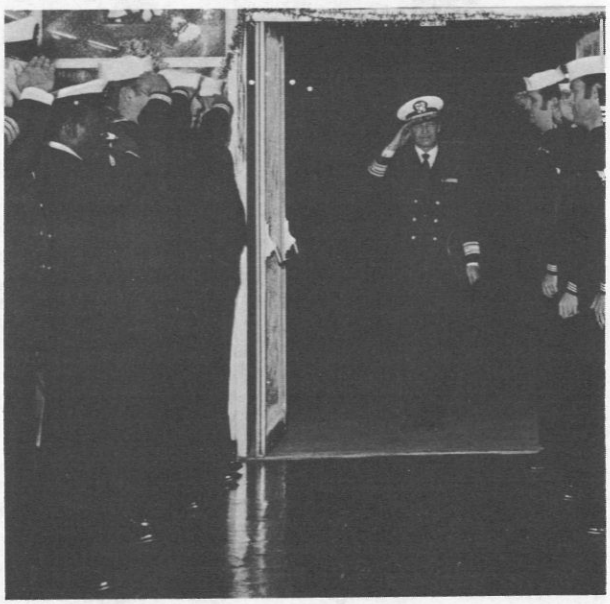
CDR Donald O. Castell, MC, USN (CAPT selectee)
Gastroenterology Editor, U.S. NAVY MEDICINE, and
Head, Gastroenterology Branch,
Naval Hospital Philadelphia, Pa.

RADM ZIOLKOWSKI FROCKED

In the Commandant's Office of the 11th Naval District in San Diego, Calif., a frocking ceremony was held for RADM Roman G. Ziolkowski, DC, USNR-R on 21 Nov 1972.

The newly promoted dental flag officer inspected the Naval Reserve Surface Division at the Naval Reserve Center, Pomona, Calif., on 28 Nov 1972, when he addressed the personnel assigned to the Reserve Center.

FROCKING CEREMONY — RADM Joseph W. Williams, Jr., USN (left), Commandant, 11th Naval District, San Diego assists RADM R.G. Ziolkowski, DC, USNR-R.



ATTENTION ON DECK — RADM R.G. Ziolkowski, DC, USNR arrives to inspect the Naval Reserve Surface Division at the NRC, Pomona, Calif.

The Navy's First Trauma Center

By LCDR Richard W. Virgilio, MC, USN,*
Departments of Surgery and Clinical Research,
Naval Hospital San Diego, California.
(Photos by HM3 Bob Vogel, USN.)

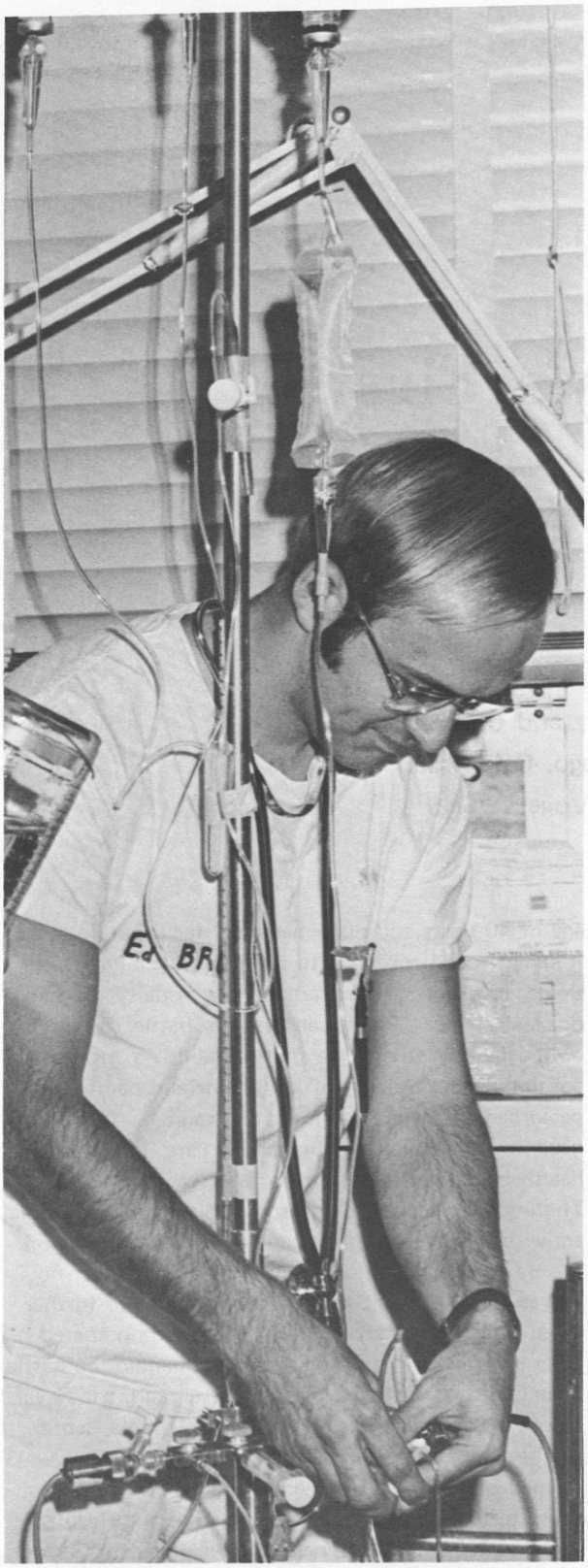
Many worthwhile contributions in the field of traumatism have emanated from experience gained in treating the critically injured during the Vietnam conflict. Acquired knowledge in the areas of transportation of the injured, treatment of shock, and the body's response to severe injury has played a major role in streamlining the care made available to the combat casualty. Clinical investigation conducted in special units, such as that which existed at the NSA Hospital in DaNang, has done much to increase our understanding of the pathophysiology of trauma and to better define our therapeutic direction in managing these critically injured patients.

The battle casualty has all but disappeared from our hospital wards but the problem of the severely injured patient continues to challenge the military physician. With the increase in highway accidents, trauma has become the leading cause of death for those under the age of 40 years and our emergency facilities are more frequently confronted with the critically injured patient. In order to give the highway casualty the same optimal chance of survival that the battle casualty obtained in Vietnam, we must establish a means of continuing the training of physicians and paramedical personnel in the management of trauma. There is a need to improve not only patient care, but also our health care delivery system for the seriously injured. There is a critical need to promote, and to keep viable active clinical research concerned with the body's response to severe injury. Military medicine can no longer afford to wait for a hostile conflict to further these objectives, lest we find ourselves unprepared both intellectually and logistically to handle the battle casualty. In an effort to attain these goals, the Naval Hospital San Diego has established a Trauma Center.

The Trauma Center has as its nucleus a newly formed branch of the General Surgery Service. A full-time staff member has been assigned as the Head of the Trauma Branch. General Surgery residents spend six months on the Trauma Service; three months are so scheduled during their first year, and another three

*Head, Trauma Branch, Surgical Service, Naval Hospital San Diego, Calif.

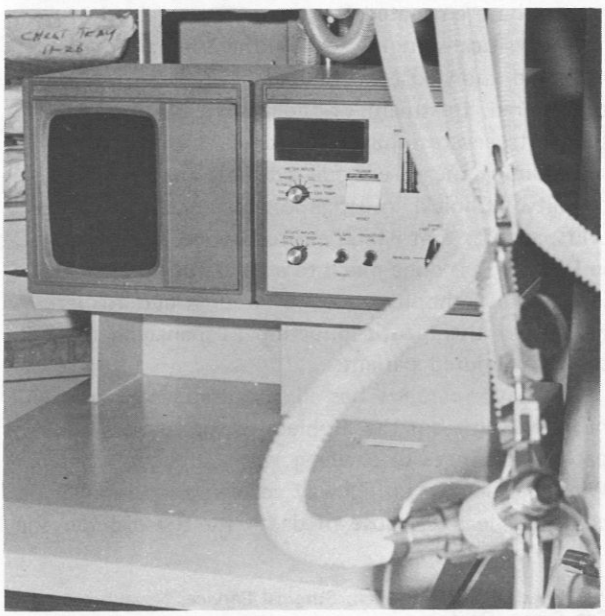
The opinions or assertions contained herein are those of the author and are not to be construed as official, or reflecting the views of the Navy Department or the Naval service at large.



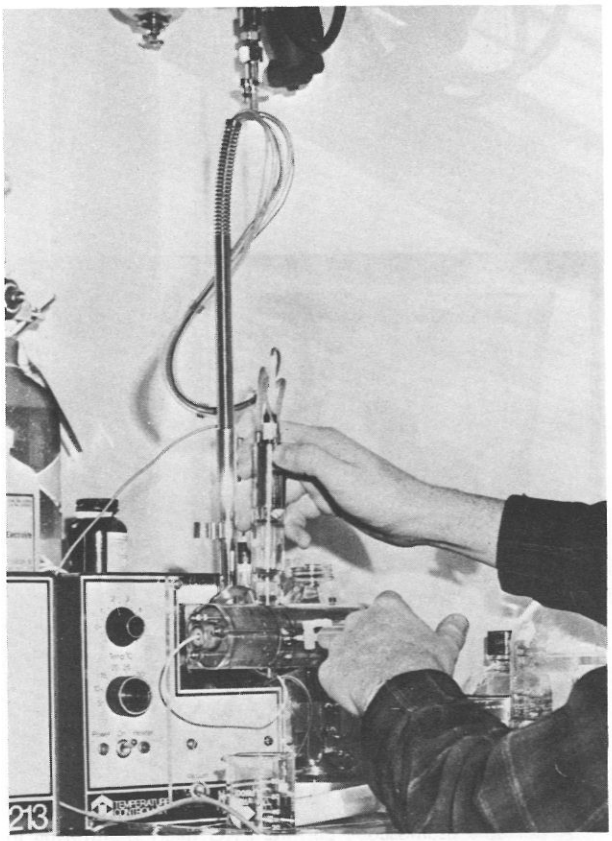
LINES READY . . . HM3 Ed Bruce makes proper IV stopcock adjustment prior to taking computer readings.

months are also scheduled during their third year. There is always an orthopedic resident on the service, and intermittently residents from other surgical subspecialties spend varying amounts of time on the service. This group of physicians has as its sole responsibility the care of the multiple-injury patient, from the time of the initial accident to the time of discharge. Immediate consultation is available with the staff of the various surgical subspecialties involved in the care of the trauma patient. The concentrated form of exposure which this arrangement offers is necessary in any training program if we are to produce young physicians who are qualified to meet the formidable challenge created by the critically injured.

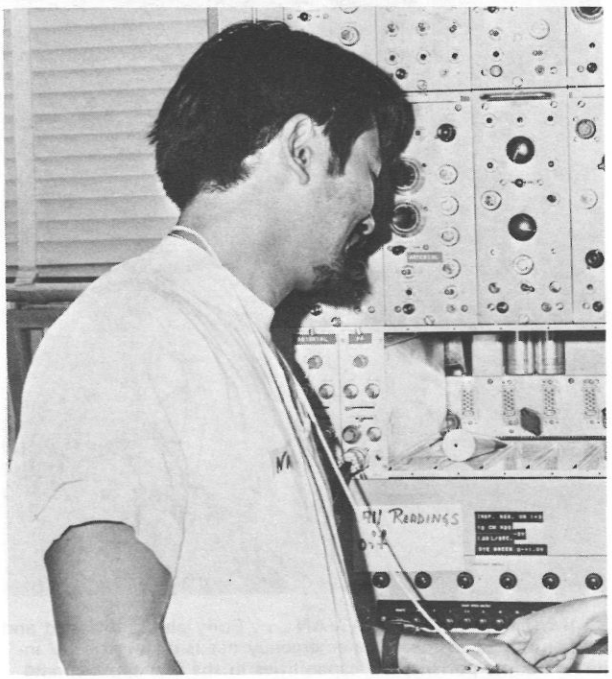
A special two-bed trauma study unit is situated within the surgical intensive care unit. Admitted to this unit are the more severely injured patients. The latest in sophisticated electronic monitoring equipment is utilized in this area for patient monitoring, to measure complicated cardiopulmonary parameters. The knowledge which these measurements provide is well beyond that usually available to the general intensive care unit patient, and greatly aids the staff in planning a rational therapeutic approach to these complex problems in trauma. The availability of this extensive monitoring system has opened the door for productive clinical research into the pathophysiology of trauma. It has become possible to simultaneously supply the finest patient care available, improve the training of physicians



RESPIRATORY COMPUTER . . . New patient computer cart used in the Trauma Center for measuring various respiratory parameters.

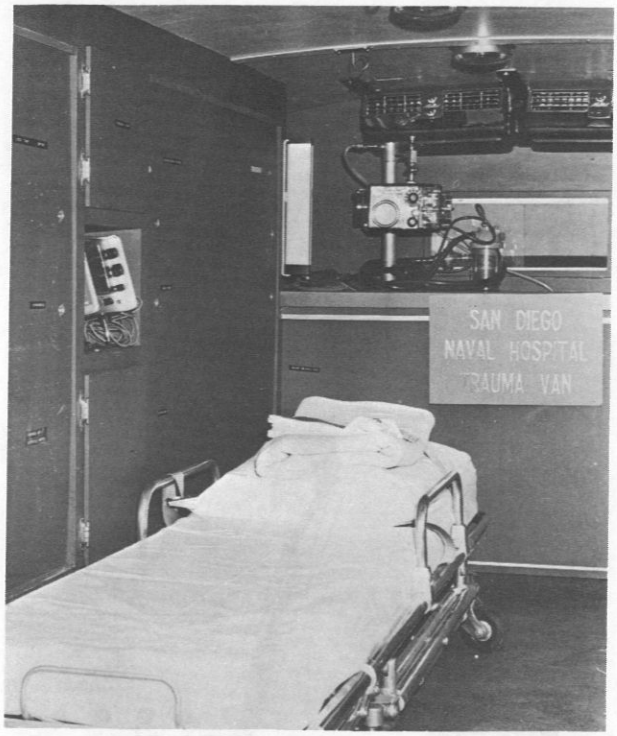


BLOOD GAS DETERMINATION . . . The careful hands of civilian cardiopulmonary technician Noel Olson perform a blood gas test in the Trauma Center's own cardiopulmonary lab.



AN ASTUTE EYE . . . HM3 Les Nakasone keeps a watchful eye on the Trauma Center computer. The flip of a switch provides a graphic reading of arterial pressure, pulmonary arterial and wedge pressures.

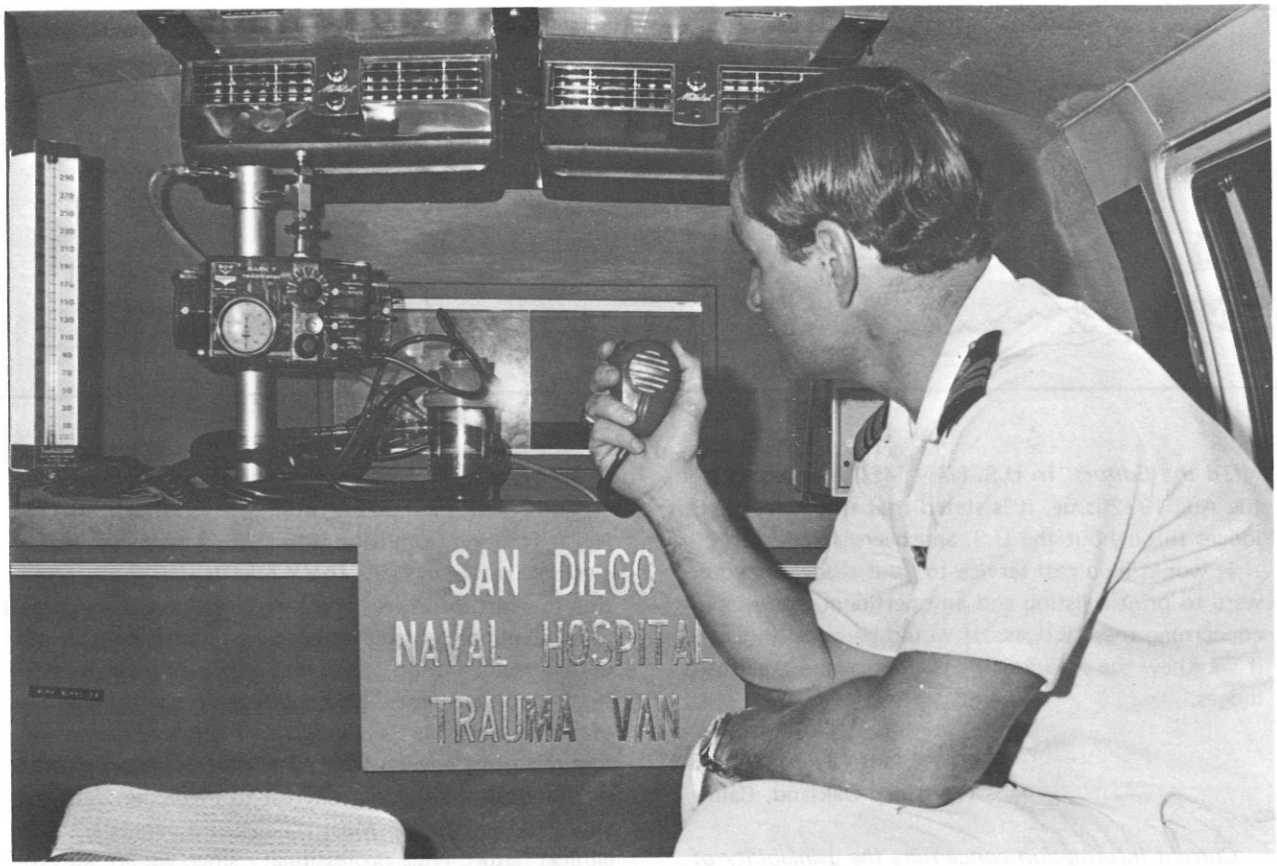
READY FOR ACTION . . . The Trauma Van awaits call outside Emergency Room of Building 26. A Trauma Center physician is available 24 hours a day.



INSIDE THE TRAUMA VAN . . . Fully air-conditioned and well equipped to meet the emergency needs of a critically injured trauma patient, the capabilities in the van approximate those in Surgical Intensive Care. Note Bird respirator positioned above the sign.

A portable oscilloscope permits EKG heart monitoring in the Trauma Van.

WITHIN THE VAN . . . The author demonstrates ready availability of self-contained defibrillator.



LISTEN CLOSELY . . . LCDR R.W. Virgilio demonstrates two-way radio aboard Trauma Van. The radio not only enables direct contact with the hospital before arrival, but also allows the doctor to inform awaiting physicians of the patient's condition.

and paramedical personnel and conduct pertinent clinical research with obvious military relevance.

The Trauma Center is also actively involved in improving the health care delivery system presently available to the injured military man, or his dependents, in the San Diego area. An emergency transport vehicle or trauma van has been outfitted with the latest devices in resuscitative equipment so that it can safely transport the most critically injured victims, both from the scene of the accident and also from local hospitals, where only limited treatment is available. One of the Trauma Service physicians is available 24 hours a day to supply professional coverage for the vehicle. By supplying this peripheral service we can now insure that our patients are receiving the optimal quality in trauma care which is available in the San Diego area. The value of high quality care at the start is inestimable.

The Trauma Center provides, during peacetime a dynamic system wherein military medicine can operate to improve medical management of the trauma patient. The organization of the Trauma Center will allow the Navy to continue vital investigational work on the pathophysiology of trauma such as that conducted in Vietnam. Many questions concerning the body's response to severe trauma remain unanswered and we cannot afford to wait for another hostile conflict before providing the answers. Only by being as organized and aggressive in our approach to the highway casualty, as we are in handling battle casualties, can we hope to improve survival rates in these critically injured patients.

NEW BUMED ZIP

The Navy Bureau of Medicine and Surgery in Washington, D.C., has now changed its mailing ZIP CODE to 20372 (vice 20390). Please note.

To the Editor: In U.S. NAV MED, on page 49 of the Aug 1972 issue, it is stated that there are 50 Navy lodges throughout the U.S. and overseas.

It would be a real service to your readers if you were to print a listing and any pertinent information concerning these lodges. It would be equally helpful if we knew the locations of the Army and Air Force lodges.

CAPT H.N. Dean, MC, USN
Nav Hosp Oakland, Calif.

Current information concerning the availability of temporary lodging at certain Naval facilities is contained in BUPERS Instruction 11107.1 and 11107.2 series. Copies of these instructions are distributed to all ships and stations having Navy personnel attached and should be available at local personnel offices. It is to be hoped that this information has now been disseminated at your hospital, since that is the purpose of the instruction. With our space limitations, we find it difficult to reprint such material in its entirety.

There are available commercial booklets, at a nomial cost, which have compiled information on the temorary lodging programs for the three military services. They are:

1) TEMPORARY MILITARY LODGING ($1.25)

Military Living Magazine
Military Marketing Services, Inc.
1325 South Glebe Road
Arlington, VA 22204

2) MILITARY LODGING (published in two editions, Eastern or Western Edition)

Business Services, Inc.
300 East Plume Street
Norfolk, VA 23510

To the Editor: Upon reporting to my new duty assignment as the Medical Administrative Officer, U.S. Naval Training Command, Morocco, I reviewed the available copies of U.S. NAVY MEDICINE for information to assist me in reestablishing the billet. There seems to be an almost complete absence of material on Health Care Administration, personnel administration and supply management. This could be in part the result of the policy of U.S. NAVY MEDICINE as stated inside the front cover: ". . . timely up-to-date items of official and professional interest to medicine, dentistry and allied sciences." Most articles and papers are of a clinical nature (vice professional - since we are all professionals) and while I enjoy reading about "Calcaneal Stress Fractures" . . . I find articles such as "Health Care Delivery: Second Annual Conference" much more beneficial.

There must be hundreds of topics which members of the Medical Service Corps could contribute which would be beneficial. Such articles should be solicited and encouraged. I am sure the Naval School of Health Care Administration could provide a wealth of material for publication, initially, which may induce others to contribute.

LT(jg) T.A. Grimes, MSC, USN
U.S. Naval Training Command
Base Medical Dept.
FPO New York 09544.

LT(jg) Grimes has made a valid suggestion. How about it, Medical Service Corps?

To the Editor: While in no way detracting from the apparent excellent reenactment of the Thanksgiving initiated by the Pilgrims at Plymouth in New England, I think it should be brought to your attention that this was not the "first Thanksgiving celebration" as

you can see by the enclosed copy of the first Thanksgiving proclamation. This was done in Virginia in 1619, a good two years before the Pilgrims had their Thanksgiving in Massachusetts.

Accordingly, the staff of the Naval Hospital Charleston, S.C., should feel even a closer affinity to Thanksgiving as it originated in a nearby southern state.

LCDR William M. McCarty, MC, USNR
2312 Fifteenth Street
Troy, NY 12180

Dr. McCarty thoughtfully enclosed a copy of The first Thanksgiving proclamation as presented by The New York Public Library's Manuscript Division.

While it is generally agreed that heads bowed in the New World's first giving of thanks in the Berkeley settlement in Virginia on 4 Dec 1619, where an official Thanksgiving Proclamation ordained a day of thanks and prayer, the observance was apparently sternly religious in tone and extent.

The first Thanksgiving dinner, however, might be said to have occurred in the autumn harvest of 1621 in Plymouth, and although the feast was hardly sumptuous, food and board were shared with the Indians.

The Pilgrims' get-together with the Indians (for feasting) is thought by many to be what President Lincoln had in mind when he proclaimed the last Thursday of November as the national holiday of Thanksgiving.

At any rate, it would seem historically accurate to conclude that although an official Proclamation of Thanksgiving directed religious observance of the day in Dec 1619 in Virginia, the first Thanksgiving Dinner (or celebration) occurred in Plymouth in 1621, when Pilgrims and Indians shared food, friendship and entertainment for a period of three days.

To the Editor: I would like to raise several questions in reference to Dr. Brohm's paper, "Malignant Hyperpyrexia in a Three-Year-Old Girl: Report of a Case," which appeared in U.S. NAV MED 60:31, Nov 1972.

1) I am curious as to the etiology of the tachycardia presented by this child prior to induction, a rate of 120-160 beats per min., the normal rate for a child of this age being 60-100.

2) Since her body temperature was elevated on admission and again at the time of discharge, one tends to question if some other undetected illness might have been present. Is a temperature of 102° F to be interpreted as a mild temperature elevation, or a manifestation of malignant hyperpyrexia?

3) Most pediatricians have long since abandoned the alcohol and ice bath procedure as treatment of an elevated temperature. The peripheral vascular constriction resulting from the procedure may indeed cause the cor temperature to rise and sequelae of inhalation intoxication can attend the use of alcohol. Rapid cooling is rarely indicated for a temperature of 102° F. and a tepid bath is usually much more effective.

LCDR Robert W. Browning, MC, USNR-R
Southern California Permanente Medical Group
1050 West Pacific Coast Highway
Harbor City, Calif. 90710

(We referred the above letter to coauthor CAPT G.I. Balas, MC, USN, Chief of Anesthesiology Dept. at Naval Hospital Great Lakes.—Ed.)

I am pleased to reply and consider the comments offered by Dr. Browning.

To take the points in sequence:

1) Our three-year-old patient's preinduction tachycardia of 120-160 beats per minute could be explained on the basis of either the atropine, and/or the extreme apprehension of the patient. However, the normal range in this case I would peg at 80-120, not 60-100 beats per min.

2) Secondly, 102° F could very well be considered a mild temperature elevation if the etiology were specific and not alarming in itself. However, when the preinduction temperature is 98.6° F and rises to 102° F in a period of 10-15 minutes, especially in the face of a creatine-phosphokinase (CPK) level above 200 International Units, the situation is far from reassuring or ordinary. Some recent articles point out the catastrophic nature of the syndrome which is 65% fatal. (See articles by Zsigmond in Anesth Analg, Current Researches, 51:5, p. 827-840 and by Britt, p. 841-850.)

After reading whatever has been reported on the malignant hyperpyrexia syndrome through 1972, I feel certain that anyone could be convinced of the utter futility of tepid baths in this situation.

3) Finally, it would appear that these patients cannot be saved even with complete surface cooling, including rapid packing in ice, without internal cooling. Beyond early application of cooling measures of heroic proportions (catch the rising temperature, even before 102° F is reached, if possible), treatment of acidosis and immediate cessation of surgery and anesthesia are essential to success.

Just one last point. During my time at Naval Hospital San Diego between 1964 and 1970, three apparently healthy young patients were lost to this syndrome. The tragedy occurred in one case, despite institution of heroic cooling measures (including ice water lavages and enemas) at a temperature level of 102° F.

CAPT G.I. Balas, MC, USN
Naval Hospital Great Lakes, Ill.

MIRAMAR MINI-CLINIC

A "Mini-Clinic," a new modular concept utilizing modern trailers to provide instant medical spaces, was formally opened as a Naval Air Station Miramar dispensary addition at 1430 on 12 Nov 1972.

Four physician's consultation rooms are arranged in suite fashion, enabling the physician to consult with the patient in his office, while additional patients are being readied in the two adjoining exam rooms.

The resultant increase in capability will have a two-fold benefit for the patients utilizing medical services at Miramar. It will provide for a greater number of patients and will do so in a more efficient and convenient manner.

Additionally it will allow specialists from the Naval Hospital to regularly provide clinics for dependent women, in obstetrics, gynecology and pediatrics.

CDR Frederick C. Leisse, Miramar's Senior Medical Officer, feels that the North San Diego area's Navy population stands to realize substantial benefits from this expansion, and that regionalization was the only means by which this could have been effected. He voiced the hope that with success in the initial specialty clinics, other services now available only at the Naval Hospital might be programmed for Miramar by the Regional Medical Center.

The workload at the Regional Dispensary at Miramar has been steadily increasing since the Regional Medical Center was established on 1 Jul 1972.

While the active duty patient population has remained relatively stable, a marked and progressive increase in the dependent/outpatient workload has been noted.

Although additional physicians have been assigned to meet the demand, the limitations of the facility itself have precluded the satisfaction of this expanding outpatient demand.

The Mini-Clinic addition, coupled with some internal organizational changes to facilitate the expansion, are seen as the answer to the current problem. A higher standard of medical care and service at Miramar is the ultimate goal! — PAO, Naval Air Station Miramar, Calif.

CUTTING THE RIBBON — RADM Herbert G. Stoecklein, MC, Director of the Eleventh Naval District Navy Regional Medical Center (right) cut the ribbon at the opening of the new Mini-Clinic at the Miramar Naval Air Station. Assisting is "Miss Fightertown" Debra Wiley and CAPT James H. Foxgrover, Commanding Officer, Naval Air Station, Miramar.

FORMAL OPENING — RADM Herbert G. Stoecklein, MC, Director of the Navy Regional Medical Center in San Diego addresses the audience at formal opening of the new Mini-Clinic at Naval Air Station Miramar. Seated at the left is CAPT James H. Foxgrover, Commanding Officer, Naval Air Station Miramar and CAPT Paul Johnson, CHC, Senior Chaplain.

Notes and Announcements

RETENTION QUESTIONNAIRE

NOW IS THE TIME FOR INPUT

It is expected that the questionnaire on retention, first mentioned in the December issue of *NAV MED* will be in your hands at the end of Feb. Again, it cannot be emphasized too strongly that your cooperation in this venture is essential to help us improve the Medical and Dental Corps.

One important aspect of the questionnaire will entail a series of questions to be answered by your wife/husband. We hope that you will take the questionnaire home with you and that you both will take the time to give the questions serious consideration.

If problems are to be resolved, they must first be defined. The purpose of this exercise is to help appropriate administrators to recognize the needs of all of us. Those who decline the opportunity to pinpoint difficulties have no right to expect that those difficulties will be removed.—Code 31, BUMED.

CHAMPUS FLASH

Pending change to appropriate directives, DD Form 1251 (Nonavailability Statement) will no longer be issued routinely to an expectant mother when she wishes to use the method known as "natural childbirth."

Since the natural childbirth method is now used when requested in some uniformed services medical facilities, the decision to issue a Nonavailability Statement should be based upon the actual nonavailability of the natural childbirth method in the uniformed service facility issuing the statement.—Health Benefits Counselor Bulletin, BUMED.

DELETION OF NAVAL RESERVE BILLET IN DENTAL DIVISION

By direction from higher authority, the Chief of Naval Operations has imposed a 25% reduction in headquarters' staff. As a result of this decision, the Reserve Section Billet, Dental Division, was deleted and CAPT Farrell was reassigned as Executive Officer, Naval Dental Clinic, Norfolk, Va.

As of 1 Feb 1973, the functions of the Reserve Section were assumed for the most part by the District Dental Reserve Program officers. Inactive duty Reserve dental officers should direct their correspondence concerning Reserve affairs to their cognizant Directors, Dental Activities/District Dental Officers for disposition. Reserve dental matters that cannot be resolved at the District level will be referred to the Chief, Bureau of Medicine and Surgery (Code 6) or to the Chief of Naval Personnel (Pers D). CAPT John B. Holmes, DC, USN of the Personnel Branch, telephone (202) 254-4289, Autovon 294-4289 will assume the duties of CAPT Farrell and will be assisted by Mrs. Ruth H. Cook, civilian secretary for Reserve affairs, telephone (202) 254-4282, Autovon 294-4282.

The decision to delete the Reserve Section Billet in the Dental Division was made by higher authority and this action in no way should be interpreted as a diminution in the emphasis placed by BUMED on the Reserve Program.—Code 613, BUMED.

A PATIENT'S BILL OF RIGHTS

Affirmed by the AHA Board of Trustees, 17 Nov 1972

The American Hospital Association (AHA) has presented a Patient's Bill of Rights with the expectation

that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital organization. Further, the Association formulated these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. The information should be made available to an appropriate person in his behalf, when it is not medically advisable to give such information to the patient. He has the right to know by name, the physician responsible for coordinating his care.
3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information, for informed consent, should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.
4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.
5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.
6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.
7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service and/or referral as indicated by the urgency of the case. When medically permissible a patient may be transferred to another facility only after he has recieved complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.
9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician, or a delegate of the physician, of the patient's continuing health care requirements following discharge.
11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.
12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalogue of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures

success in the defense of the rights of the patient. —American Hospital Association, 840 North Lake Shore Drive, Chicago, Ill 60611.

CDR WATSON COMPLETES TOUR

Dr. C. Gordon Watson, Executive Director of the American Dental Association (ADA) and a Naval Reserve commander recently completed two weeks of ACDUTRA in San Diego, where he toured Naval dental facilities and visited Naval Reserve Dental Companies.

VIEW DENTAL FACILITIES—CDR C.G. Watson, DC, USNR (left), ADA Executive Director, was accompanied on a recent tour of Navy activities by: RADM M.G. Turner, DC, USN (center), Director of Dental Activities, 11TH Naval District; and CDR J.T. Gentry, DC, USNR, CO Naval Reserve Dental Company 11-1.

SPRING SYMPOSIUM ON TRAUMA

The Department of Surgery, Naval Hospital Portsmouth, Va., will present its seventh annual spring Trauma Symposium on Friday, 16 March. The subject of this year's session will be "Penetrating Injuries," which are being seen with increasing frequency in both civilian and interbellum military practices.

Five experts in their special fields will present the latest thoughts on the pathophysiology, diagnosis and management of penetrating injuries. Their individual presentations will be followed by a panel discussion.

For additional information on the symposium, contact: CAPT Joseph Mullen, MC, USN, Chief of Surgery, Naval Hospital Portsmouth, Va., 23708. Telephone: (703) 397-6581, ext. 735.—PAO, Nav Reg Med Center, Portsmouth, Va.

SHOCK AND TRAUMA SEMINAR

A Seminar for Clinical Advances in Shock and Trauma will be conducted 23-25 April 1973 at Sheraton Inn, San Diego Airport, San Diego, Calif. The title was carefully chosen to indicate the clinical emphasis of this meeting which is being sponsored by the Office of Naval Research and the Surgery Department, Naval Hospital San Diego.

The objective is to bring together the leading investigators in the field of shock and trauma, to address the question: "How can new research information be applied at the bedside of the patient suffering from shock following trauma?"

A preliminary outline of the program is as follows:

April 23rd. Diagnostic Methods and Concepts.

Morning Session.

Moderator: Max H. Weil, M.D., Ph.D., Professor of Medicine, Director of Shock Unit, Univ. of Southern California.

Speakers: John J. Osborn, M.D., Prof. of Cardiovasc. Research, Univ. of Calif., San Francisco.

J.F. Damman, M.D., Prof. of Surgery, Univ. of Virginia.

Claude Lenfant, M.D., Associate Director, National Heart & Lung Institute, NIH, Bethesda.

Afternoon Session.

Moderator: Richard M. Peters, M.D., Prof. of Surgery & Bioengineering, Univ. of Calif., San Diego.

Speakers: John B. West, M.D., Prof. of Medicine & Bioengineering, Univ. of Calif., San Diego.

Frank A. Oski, M.D., Prof. of Pediatrics, Univ. of Penn.

Louis D. Homer, M.D., Ph.D., Senior Investigator, Naval Medical Research Institute, NNMC.

April 24th. Application of Physiologic Concepts.

Morning Session.

Moderator: Marshall J. Orloff, M.D., Prof. and Chmn. of Surgery, Univ. of Calif., San Diego.

Speakers: Lerner B. Hinshaw, Ph.D., Prof. of Physiology, Univ. of Oklahoma.

Lazar Greenfield, M.D., Prof. of Surgery, Univ. of Oklahoma.

Herbert J. Proctor, M.D., Assoc. Prof. of Surgery, Univ. of No. Carolina.

Afternoon Session.

Moderator: William C. Shoemaker, M.D., Prof. of Surgery, Mt. Sinai Medical School.

Speakers: Charles J. Carrico, M.D., Assoc. Prof. of Surgery, Univ. of Texas at Dallas.

Jay N. Cohn, M.D., Assoc. Prof. of Med., George Washington Univ.

Gerald S. Moss, M.D., Prof. of Surgery, Univ. of Illinois.

April 25th. Principles of Treatment.

Morning Session.

Moderator: Louis R.M. Del Guercio, M.D., Prof. & Chmn. of Surgery, New Jersey College of Medicine.

Speakers: Herbert S. Shubin, M.D., Prof. of Med., Assoc. Director of Shock Unit, Univ., of Southern Calif.

C. Robert Valeri, M.D., Director, Navy Blood Research Lab., Boston Nav. Hosp., Chelsea, Mass.

Pierre Galetti, M.D., Ph.D., Dean of Brown Univ. Med. School, Director of NIH Membrane Oxygenator Program.

PLEASE DETACH AND MAIL

RICHARD W. VIRGILIO LCDR MC USN
Chairman, C.A.S.T. Seminar
Box 649
Naval Hospital
San Diego, California 92134

ADVANCE REGISTRATION

Please register me for the Seminar: Clinical Advances in Shock and Trauma. April 23-25, 1973

Name _____

Address _____

City _____ State _____ Zip _____

Generalist _____ Surgeon (type) _____

Resident _____ Intern _____ Other _____

Registration fee enclosed YES _____ NO _____

****

REGISTRATION FEE - NONE REQUIRED

****

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Date Arriving _____ Hour _____ A.M. ☐ P.M. ☐

Date Departure _____

Name _____

Address _____

City _____ State _____

Rooms will not be held after 6 P.M. unless stated above.

Maximum intervals for free interchange among speakers and audience will be provided, with open opportunity to question and directly challenge the views expressed.

This seminar is designed to represent an intensive course, at a postgraduate level which describes the clinical usefulness of the latest developments in this field. In this context, and in view of the unsolved problems presented by the critically ill patient with respiratory failure, sepsis and other frustrating complications of trauma, the seminar should prove valuable for resident and staff physicians of all specialties who care for the seriously ill.

Lodging will be reserved for attendees at the Sheraton Inn and those desiring to share a room (at less expense) should so indicate on their application form.

Attendance is limited to 250, so reservations should be made as early as possible. Mail form to: LCDR R.W. Virgilio, MC, USN; Chairman, CAST Seminar, Box 649, Naval Hospital San Diego, California 92134.

Further details, including confirmation of reservations and the final program, will be sent in the near future.

Suggested Application Form is provided.

ANNUAL SYMPOSIUM NAVAL HOSPITAL BOSTON

The Fourth Annual Spring Symposium of the Naval Hospital Boston will be held on 16–18 May 1973. The theme will be *A Forward Look in Medicine,* with presentations focusing on areas of current research and development that promise to enhance the quality and efficiency of future health care. All interested civilian and military physicians, dentists, nurses, and paramedical personnel are invited to attend and participate.

Any individual wishing to participate is asked to submit an abstract of his paper, no longer than 200 words, prior to 15 March 1973. All abstracts, scientific exhibit applications, and requests for further information should be directed to: Captain J.M. Young, MC, USN, Program Co-Chairman, Naval Hospital Boston, Chelsea, Mass. 02150.

1973 SPRING MEETING FOR AGARD

RADM Oscar Gray, Jr., MC, USN, CO, Naval Aerospace and Regional Medical Center, Pensacola, Fla., has announced that Frederick E. Guedry, Jr., Ph.D., Chief of the Psychophysiological Sciences Division at the Naval Aerospace Medical Research Laboratory, will be Co-Chairman at an international scientific session to be held at the Naval Aerospace Medical Institute 14–17 May 1973.

About 100 members of the Medical Panel of the Advisory Group for Aerospace Research and Development (AGARD), North Atlantic Treaty Organization (NATO) will assemble in Pensacola for their 1973 Spring meeting, the first to be hosted by the U.S. Navy. The group meets twice a year in different countries to discuss new research related to aerospace medicine.

The session to be co-chaired by Dr. Guedry and Dr. Martin P. Lansberg, Director, National Aeromedical Center, Soesterberg, The Netherlands will address the use of nystagmography in aviation medicine. Its use for clinical diagnosis has increased recently in the fields of neurology and otology. Because of the special problems in aviation related to spatial orientation, vertigo and motion sickness, nystagmography is potentially relevant to aviation medicine. A related

CO-CHAIRMAN OF AGARD MEETING—Frederick E. Guedry, Jr., Ph.D., Chief of the Psychophysiological Sciences Division at The Naval Aerospace Medical Research Lab. at Pensacola.

application involves the diagnosis of vestibular symptoms encountered during and after deep underwater diving. In addition, nystagmography is used in investigations of physiologic and psychophysiologic correlates of human performance during accelerative forces in flight and flight simulation.

"I have been gratified by the response to our call for papers; we have already received abstracts from researchers in ten countries," said Dr. Guedry.

Dr. Robert L. King Jr., a member of the Pensacola Chapter of the Navy League, is making plans for members to host the foreign dignitaries at a Pensacola Beach reception during their visit.—PAO, Naval Aerospace and Regional Medical Center, Pensacola, Fla.

AWARDS AND HONORS

Distinguished Service Medal

RADM Rufus J. Pearson, Jr., MC, USN

Legion of Merit

RADM Harry S. Etter, MC, USN
CAPT George M. Ricketson, MC, USN

Meritorious Service Medal

RADM John P. Arthur, DC, USN
LCDR James R. Erie, MSC, USN
LCDR John R. Knight, MSC, USN
CAPT Mary T. Lynch, MC, USN

Meritorious Service Medal (Con.)

CDR Irene A. Sullivan, NC, USN

Navy Commendation Medal

CDR Joseph L. Graves, MSC, USN
LCDR Ralph W. Johnson, MSC, USN
HM1 Charles Edward Miklinski, USN
CDR Lavern E. Nichols, MSC, USN

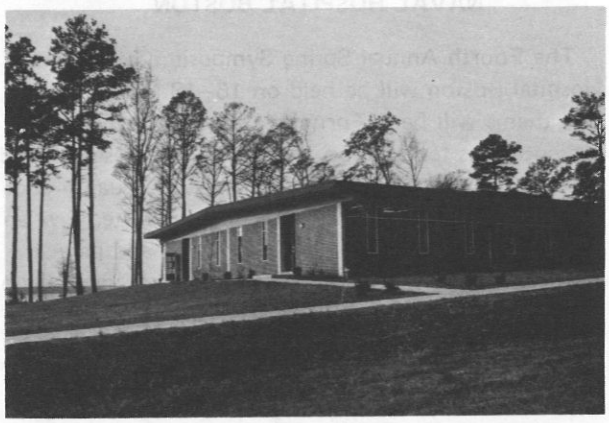
Navy Achievement Medal

HM1 David F. Clark, USN
HM1 James B. Jackson, Jr., USN

NEW DENTAL CLINIC AT CAMP LEJEUNE

On 16 Nov 1972, a new dental facility for the Second Dental Company, FMFLANT, was dedicated. The ceremony was attended by many notables who addressed the guests present for the occasion. Among those speaking were Lieutenant General G. C. Axtell, USMC, FMFLANT; Major General F. Haynes, Commanding General 2nd MARDIV; RADM W. H. Hagerman, DC, USN, Commanding Officer, Naval Graduate Dental School, who represented the Chief of the Dental Division, Bureau of Medicine and Surgery; and Mr. B. Teachy, Mayor of Jacksonville, N.C.

This new air-conditioned clinic has 12,580 square feet of space providing over 20 dental treatment rooms, one examination room, three prosthetic treatment rooms, four oral hygiene rooms, and a surgery suite composed of two operatories. In addition, ancillary spaces such as X-ray rooms, and prosthetic laboratories which are equipped to provide all manner of prostheses make it possible for the 24 dental officers stationed with the 2nd Dental Company to render complete dental health care to the personnel of the 2nd Marine Division. This is the first time that all dental facilities of the 2nd Dental Company have been housed in one building.



NEW DENTAL FACILITY—2nd Dental Company now functions in a new dental clinic at Marine Corps Base, Camp Lejeune, N.C.

Although the 2nd Dental Company occupies the clinic building, it belongs to Marine Corps Base. FMF Units cannot own permanent facilities since the nature of their mission is one of mobility.

CAPT A. P. Giammusso, DC, USN is Commanding Officer; LT M. G. Hostetler, MSC, USN is Administrative Officer.

AMERICAN BOARD CERTIFICATIONS

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LCDR Peter T. Hansen, MC, USNR
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Code 3A
Bureau of Medicine and Surgery
Navy Department
Washington, D.C. 20372
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United States Navy Medicine

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NOTICES should be received not later than the third day of the month preceding the month of publication.

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I DO — HM3 Glenn Turner (left) decided to go one better than his contemporaries by reenlisting while perched on a helicopter hoist. LCDR Lee Wright, Officer in Charge of the Search and Rescue Detachment at Sherman Field, is shown administering the reenlistment oath to Turner who is one of his crew members. HM3 Turner had hoped for a more exciting setting – in the air, but settled for this one on the ground due to inclement weather.—PAO, Nav Aerospace & Regional Med Center, Pensacola, Fla.